Michigan's

Jurisdictional Plan 2012-2015

November 2012

Submitted by the Michigan Department of Community Health (MDCH), Division of Health, Wellness, Disease Control (DHWDC),HIV/AIDS Prevention Intervention Section (HAPIS) in collaboration with the Michigan HIV/AIDS Council (MHAC)

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Michigan's 2012-2015 Jurisdictional Plan (JP) and Statewide Coordinated State of Need (SCSN) could not have been created without the collaborative efforts of so many agencies, providers, Ryan White grantees, and community stakeholders throughout the state who are committed to meeting the needs of people and communities affected by HIV/AIDS. In acknowledgement of their hard work and dedication to the planning process and this comprehensive plan, the names of contributing agencies are listed below.

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Community AIDS Resources and Education Services
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Midwest AIDS Education and Training Center (MATEC)
Michigan Cross Parts Quality Collaborative (MCPQC)
Michigan State University
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Michigan Medicaid
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SEMHAC Long Range/Strategic Planning Committee
MDCH Office of Drug Control Policy
University of Michigan, Internal Medicine – Infectious Disease (Part C)
Central Michigan Health Department

All members of the Michigan HIV/AIDS Council (MHAC) Needs Assessment and Comprehensive Plan Committees, as well as the staff of the Continuum of Care and the Community Partnership and Prevention Units, and the Sexually Transmitted Disease and Health Disparities Reduction and Minority Health Section Managers.

Michigan HIV/AIDS Council

June 12, 2012

Gbolahan Cole
Project Officer
Division of Service Systems
HIV/AIDS Bureau, HRSA
5600 Fishers Lane, Room 7A-55
Rockville, MD 20857

Dear Dr. Cole:

The Michigan HIV/AIDS Council's Executive Committee reviewed the 2012-2015 Michigan Comprehensive Plan and Statewide Coordinated Statement of Need and found it fully responsive to the guidelines identified in the both the Comprehensive Plan and Statewide Statement of Need guidances.

The MHAC Executive Committee voted on behalf of the full body of the Council to approve this document for submission without reservation.

The chair and two community co-chairs of MHAC are designated as signatories to the letter of concurrence.

Sincerely,

Leanne Savola, Chair | David Ponsart, Co-Chair | Royale Theus, Co-Chair

TABLE OF CONTENTS

Introduction

The Michigan Department of Community Health (MDCH), Division of Health, Wellness and Disease Control (DHWDC), HIV/AIDS Prevention Intervention Section in collaboration with the Michigan HIV/AIDS Council (MHAC) is responsible for the development the Michigan's Comprehensive and Jurisdictional Plan. In June of 2012, the DHWDC, through engagement with the MHAC planning body and other stakeholders, developed and submitted the Statewide Coordinated Statement of Need and Comprehensive Plan (SCSN) to the Health Resources and Services Administration (HRSA). Simultaneously, the engagement process used to develop the SCSN was also used to develop this Jurisdictional Plan. The DHWDC views HIV prevention and care in the State of Michigan as one consolidated, interdependent effort to combat this disease. The SCSN, as one component of the continuum of activities to address HIV in Michigan, serves as the launch pad for the development of this Comprehensive and Jurisdictional Plan. As both the SCSN and the Jurisdictional Plan work in concert to serve the goals of the DHWDC efforts addressing HIV, they will, from this point forward, be referred to in this document as the Plan. DHWDC and MHAC are committed to fulfilling the goals of the National HIV/AIDS Strategy in Michigan through the development, implementation and monitoring of the Plan.

The process of developing the Plan provided an important opportunity to gather data, review the range HIV/AIDS prevention and care services provided in Michigan, and to identify gaps in service, barriers to care, systems challenges, and program successes. This process also supports a dialogue among HIV prevention and care service providers, grantees and consumers, providing a critical impetus to explore innovative ideas to address emergent and/or persistent issues. The Plan is designed to cover a three-year time period (2012-2015), going beyond the annual implementation plan process, and provides a road map for developing a comprehensive system of prevention and care which addresses:

- Disparities in HIV prevention, access, and services among affected subpopulations and historically underserved communities;
- Coordination of resources among other federal and local programs;
- Needs of those who know their HIV status and are not in care, as well as the needs of those who are currently in the care system; and
- Prevention needs of both those living with HIV/AIDS and those at high risk for acquiring HIV.

The DHWDC supports a comprehensive portfolio of HIV prevention activities intended to prevent as many new infections as possible; encourage early identification of HIV infection and facilitate entry into and sustained engagement with HIV care for HIV-infected persons. The majority of publicly supported HIV prevention funding in Michigan comes from federal sources. This document presents a detailed analysis of the most current data and epidemiological trends, the needs of people living with HIV/AIDS (PLWH/A) in Michigan, and the prevention needs of the populations of those at highest risk for HIV infection. Additionally, the DHWDC funds a variety of prevention interventions and strategies through partnership with local health departments, community based organizations, hospitals, community health centers and other agencies. The DHWDC allocates funding across the state based on the epidemiology of the disease, with resources placed in the communities with highest prevalence rates.

With the steady decline in Michigan's overall public HIV prevention budget, the DHWDC has increasingly sought to optimize resources based on analysis of epidemiology as well as program effectiveness and yield. The major changes in prevention services in the past decade have included a redirection of generalized support for local public health funding from the state's 83 counties into 16 high-prevalence health departments; an increased emphasis on HIV testing and partner services; a reduction in behavioral health interventions overall, with remaining such services prioritizing HIV-positive individuals and men who have sex with men; a concentrated shift of community based prevention services into areas of higher HIV prevalence with particular emphasis on the Detroit metropolitan area; an elimination of information-based services; and a significant reduction in general media and HIV awareness campaigns.

Although these shifts have resulted in a targeted, high-yielding prevention program, they have left significant gaps in the prevention portfolio. Current gaps include little HIV prevention programming outside of the Detroit eligible metropolitan area; very limited support for behavioral interventions, particularly for high risk negatives; very limited support for programming targeted to IDU; and a lack of programming to increase awareness for general populations and to contribute to the reduction of HIV related stigma.

In 2012, Michigan's federal funding for HIV prevention was substantially reduced, thereby intensifying existing gaps. State and federal funding for STD and reproductive health programs as well as for health disparity reduction is also being substantially reduced in Michigan. This will contribute to further intensifying gaps in services as these reductions will heavily impact HIV and STD services provided by local health departments.

Process

The development of the Plan was guided by the Michigan HIV/AIDS Council's (MHAC) Comprehensive Plan Committee (CPC) and Needs Assessment (NA) Committee, and the MDCH, DHWDC, HAPIS. MHAC was established in January 2000, and is a joint prevention and care planning body with forty active members and twenty expert and at-large advisors including PLWH/A.

The Comprehensive Plan and Needs Assessment Committees include representatives from Michigan's RW funded organizations and programs. Its structure and composition is intended to facilitate equal representation and responsibility for developing the Plan and includes representatives from the MDCH Office of Drug Control Policy, Housing Opportunities for Persons with AIDS, MDCH Bureau of Epidemiology, public health agencies, and various other statewide HIV and AIDS-related organizations. Representatives from these agencies and organizations convened an all-day face-to-face meeting, as well as, a two-hour conference call to discuss the current system of care and prevention services as well as to identify needs, barriers and gaps in service, from their own data, experience and perspective.

The primary data sources for the Plan include current Epidemiology and Surveillance data, CAREWare, and HIV Event System (HES) data. Data is also included from Michigan's comprehensive statewide needs assessment survey, conducted during 2010. The needs assessment process was designed to provide the State with information on unmet needs and the barriers to care experienced by PLWH/A. The information collected through this process was then used to create the Plan. The current document combines the 2012-2015 Jurisdictional Plan with the findings of the needs assessment, the issues outlined in the SCSN, and includes the specific components detailed in both the CDC and HRSA guidance. It presents a realistic scope of what can be accomplished in this plan's three-year planning cycle through 2015.

Community Planning

Michigan's approach to implementing community planning in terms of the current national goals is presented below.

Goal One – Community planning supports broad-based community participation in HIV prevention community planning.

Objective A: Implement an open recruitment, nomination and selection process for Community Planning Group (CPG) membership.

The Membership Committee of the Michigan HIV/AIDS Council (MHAC) has responsibility for membership issues. The Committee membership is comprised entirely of MHAC members and advisors. The Division of Health, Wellness and Disease Control (DHWDC) provides technical and staff support for Committee activities.

The roles and responsibilities of the Committee are defined in the MHAC Operating Policies and Procedures. Pursuant to the MHAC Policies and Procedures, the Membership Committee establishes, maintains and conducts an open member recruitment, application and selection process. Categories of membership, the application and selection process, methods of orientation and grievance policies were developed by the Committee, endorsed by MHAC membership and are included in the MHAC Operating Policies and Procedures.

The Committee developed and implemented specific, written application and selection procedures that include criteria for selection of new members. Applications are scored, using weighted scoring and evaluated according to these criteria. This process is intended to ensure inclusion of representation from affected communities and members with relevant expertise.

The process also achieves a balance in geographic representation of members. The Committee conducts the review and provisional selection of new members, as membership vacancies occur. The Committee presents recommendations regarding applications for membership slots to MHAC for endorsement. The DHWDC staff provides technical assistance and staff support to the Membership Committee relative to application and selection activities.

Objective B: Ensure that the CPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation for key governmental and non-governmental agencies.

The MHAC Policies and Procedures specifically define categories of membership. The categories of membership, in combination with the selection criteria and procedures used by the Membership Committee, facilitate membership that reflects the state's epidemiologic profile in terms of race/ethnicity, gender, sexual orientation, and geographic representation as well as needed expertise (e.g., epidemiology, behavioral/social science, evaluation). Four of 40 membership slots are designated for persons living with HIV/AIDS, as defined in the MHAC Policies and Procedures. Four of 40 membership slots are reserved for local public health agencies, (both urban and rural) eight are reserved for representatives of community-based organizations and the remaining 24 seats are designated for affected community members. Additionally, MHAC Policies and Procedures specifically define the representation of key government agencies in community planning activities. There are two categories of advisory (i.e., voting and non-voting) MHAC members. The Policies and Procedures require that, at minimum, advisory members will include the representatives from the following organizational divisions within the Michigan Department of Community Health (MDCH): HIV Surveillance and Epidemiology Section, the DHWDC and the Office of Drug Control Policy. In addition, the Michigan Departments of Corrections and Education are to be represented. All Parts of the Ryan White Treatment Expansion Act are to be represented, as are local substance abuse and mental health providers.

Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.

The MHAC Policies and Procedures outline governance for MHAC. The Executive Committee is comprised of the Community Co-Chairs, the Health Department Chair and the Chair and Co-Chairperson for each standing Committee. The Executive Committee sets the agenda for each MHAC meeting, facilitates coordination among the committees and workgroups in achieving the mission of MHAC and provides overall direction to the body.

MHAC holds four full day meetings annually, chaired by the Community Co-Chairs. The MHAC Policies and Procedures outline specific rules related to governance including attendance, voting procedures and quorums. The Policies and Procedures specify that Robert's Rules of Order be used to govern the proceedings of MHAC. The MHAC Policies and Procedures address voting. Each member is entitled to one vote. A quorum of more than 50 percent of members is required for action on items requiring a vote.

Conflict of interest is addressed in the MHAC Policies and Procedures. All members must complete and submit a signed Conflict of Interest Disclosure Form prior to attending their first meeting. These forms are updated annually, or as relevant changes to the member's situations occur. All members are required to sign and submit Statements of Confidentiality. By signing such statements they agree to maintain in strict confidentiality any member or advisor's HIV status. Meeting guests must also sign confidentiality statements at the beginning of meetings.

All MHAC meetings are held at the same central location. Additional, separate skills-building retreats may take place at different locations across Michigan. Travel support is available to participants, pursuant to established MHAC travel guidelines with priority for travel support going to Persons living with HIV/AIDS (PLWH/A).

Pursuant to the Operating Policies and Procedures, orientation of new MHAC members is the responsibility of the Membership Committee. All new members are provided with an orientation manual, the contents of which are detailed in the Operating Policies and Procedures. The MHAC Operating Policies and Procedures, Guidance on HIV Prevention Community Planning, the Statewide Comprehensive HIV Prevention Plan and the Statewide Epidemiological Profile are included in the orientation manual. The Membership Committee conducts a new member orientation for members and advisors before each annual meeting held in March. The Membership Committee has also established a "mentorship" program for new members, wherein new members are assigned to current members to assist them in familiarizing themselves with the community planning process and answering questions about it. Current members who are PLWH/A are encouraged to volunteer to mentor new MHAC members who are PLWH/A. Those new PLWH/A members and advisors, who request a PLWH/A mentor, will be assigned one. Membership will use members who continually stand out as mentors as an ad hoc committee.

On-going training and skills-enhancement opportunities are provided to MHAC members, as needs are identified. Topics of past trainings include leadership development, cultural competence, meeting facilitation, priority setting, and conducting gap analyses. MHAC committees and workgroups, in consultation with the DHWDC staff, identify training and skills-enhancement needs.

Skills enhancement activities will also address current topics and emerging issues. Three key areas for skills enhancement prioritized by MHAC members included health disparities reduction, federal HIV/AIDS prevention and care funding, and federal and state HIV/AIDS policy and legislative issues. Other areas of interest cited by MHAC members include HIV and transgender communities, programming for African American MSM and African American women.

Travel support is provided by the DHWDC to enable the Community Co-Chairs and MHAC committee chairpersons to attend the annual National HIV Prevention Leadership Summit. In an effort to broaden the knowledge and understanding of MHAC members on a wide variety of topics, the Executive Committee ensures that every MHAC agenda includes at least one educational item. Past presentations have included: findings from needs assessment efforts, surveillance and epidemiology, overviews of CDC directly-funded HIV prevention programs,

overview of HIV/AIDS prevention and/or care programming provided by other government entities (e.g., Department of Corrections) and other partners.

MHAC committees are open to non-MHAC members. Additionally, ad-hoc workgroups are convened on population or topic-specific issues. Workgroups are also open to the participation of non-MHAC members. Qualitative methods such as interviews with community gatekeepers are most valuable in this regard. Such methods will continue to be used in needs assessment activities.

Goal Two – Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

As described in the MHAC Operating Policies and Procedures, the MHAC Comprehensive Plan Committee has overall responsibility for the Comprehensive HIV/AIDS Prevention Plan, including review of the gap analysis as well as establishing and maintaining mechanisms for priority setting. The Needs Assessment Committee has responsibility for reviewing both plans for findings from the community services assessment (CSA). The DHWDC provides technical and staff support for all committee activities. During 2009, the two committees jointly crafted a new Statewide Comprehensive Plan for 2010-2013.

The statewide Epidemiological Profile is updated biannually, most recently in 2012. The profile describes behaviorally defined priority populations, including race/ethnicity, gender, age and geographic distribution. The sources of data used in constructing the profile are described, as are the strengths and limitations of these data sources.

The African American AIDS Advisory Committee has been instrumental in advising MHAC on the disproportionate impact of HIV/AIDS epidemic in the African American community. Members of this committee sit on all other MHAC committees to provide input and expertise on cultural antecedents that affect the prevention and care needs of African Americans.

Beginning in early 2009, the DHWDC initiated a planning initiative targeted to MSM (the "Initiative"). The Initiative's Community Advisory Committee (CAC) membership consists of service providers, community members and local health department staff. Members have discussed the goals and objectives for this planning process, shared information about the HIV epidemic among MSM in Michigan, developed a vision statement and identified barriers to providing culturally competent services to MSM.

The overall goals of the Initiative are to inform best practices for HIV services targeting MSM, and to serve as a catalyst for community mobilization to address the social, political, and environmental factors that make MSM more vulnerable to HIV. The Community Advisory Committee will work in parallel with MHAC to carry out the recommendations resulting from this process. The CAC will also seek to foster sustainable partnerships between service

providers, local health departments, and community members to support MSM targeted HIV prevention efforts.

The CAC held the first wave of Community Conversations in 2010. The information gathered from each session was compiled with recommendations from other conversations to produce a comprehensive document on the HIV prevention needs, HIV-risk and protective factors of MSM, prevention strategies to utilize, and community partners to engage in the execution of these strategies at the County and City level, as well as statewide.

A second cycle of community Conversations began in April 2011, the goals were to present the findings back to the community, prioritize recommendations and to mobilize community members around local efforts improve prevention strategies for MSM**.**

Objective E: Ensure that prevention activities/interventions for priority target populations are based on behavioral and social science, outcome effectiveness, and/or have adequately been tested with intended target populations for cultural appropriateness, relevance and acceptability.

The DHWDC will continue to compile data related to effective HIV prevention interventions, drawing from the published literature and findings from local program evaluation efforts conducted by the DHWDC, its grantees and other community partners. Needs assessment activities will continue to address acceptability of interventions to priority populations.

Goal Three – Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

All DHWDC Request for Proposals (RFP) reflects these priorities and recommendations identified in the Plan. The RFP released to re-compete these resources is reflective of priorities identified thought a data-driven and consultative process.

Section I. WHERE ARE WE NOW?

Snapshot of Michigan Today

2010 US Census data identifies Michigan as the eighth largest population in the U.S., with a total population of 9,883,640 persons. Michigan is made up of 83 counties; with county populations ranging from a low of 2,156 persons (Keweenaw County) to slightly less than two million persons in Wayne County. The Detroit Eligible Metropolitan Area (DEMA), which includes Wayne, Macomb, Oakland, Monroe, St. Clair, and Lapeer Counties, represents 44% of Michigan's population. Michigan cities with populations over 100,000, in order of descending population, are Detroit, Grand Rapids, Warren, Sterling Heights, Lansing, Ann Arbor, and Flint, with populations ranging from 713,777 to 102,434.

Demographics

The racial and ethnic composition of the state was estimated to be 77% White, 14% Black, 4% Hispanic, 2% Asian, Hawaiian, Pacific Islander, and .5% American Indian. The median age of Michigan residents was estimated to be 38.9 years. The proportion of males in the overall population was lower than the proportion of females (49 v 51%).

Uninsured
In 2008 and 2009, CAREWare data show that in CY2008 of the 5,487 PLWH/A, 1,677 or 30% reported having no insurance, and in CY2009, of the 6,759 clients served, 1,767 or 26% reported having no insurance. *Kaiser Family Foundation, State Health Facts, June 2010,* reports that between 2009- 2010, 13% of Michigan residents remain uninsured.

Homelessness
The Michigan State Homeless Management Information System (MSHMIS) reports that in 2010 the number of homeless people in Michigan rose to 100,176. This follows reports in 2007 of 79,940 reported homeless in Michigan, followed by an increase to 86,189 in 2008. First time homelessness increased from 45% to 54% of total homeless. Michigan also saw a 10.8% increase in family homelessness; and 30% of homeless families are working poor (MSHMIS, 2008). The continued increase in the numbers of homeless are reflective of Michigan's continued weak economy and increasing service need.

Unemployment
The proportion reporting unemployment as of June 2012 is 8.5% statewide compared to 8.1% nationally. The number of people unemployed in Michigan peaked in August 2009 at 14.2% (http://www.milmi.org).

Description of the HIV Epidemic in Michigan
The MDCH uses various methods to analyze data and develop conclusions to guide the development of the epidemiological profiles in Michigan, which informs the Plan. Some of the methods used to analyze data for care and prevention planning include: core HIV/AIDS surveillance data, supplemental HIV/AIDS surveillance projects, communicable disease surveillance data, behavioral surveys, vital statistics, population data and service utilization data. A comprehensive *Statewide Epidemiologic Profile* is prepared and updated biannually by MDCH. The 2012 Profile is available at http://www.michigan.gov/mdch/0,4612,7-132-2940_2955_2982_46000_46003-36307--,00.html.

As of October 2012, there are 14,996 people currently living with HIV/AIDS in Michigan.
HIV disease is distributed disproportionately in Michigan. Sixty-five percent of those persons currently living with HIV in Michigan reside in the DEMA (9,708 of the 14,996 cases statewide), but only 43% of the general population resides in the DEMA. The rest of the state, referred to as "outstate," has fewer cases compared with the general population distribution. Efforts will continue to emphasize the City of Detroit as it accounts for 36 percent of all new diagnoses reported annually, even though less than 10 percent of Michigan's population reside in Detroit.

Currently, Black males in Michigan have both the highest prevalence rate (960) per 100,000 populations and also the highest number (6,308) of PLWH/A. Data tell us that Black males have eight times more cases than White males in the same size population (100,000), and Hispanic males have twice as many as White males. Among females, Black women (with a prevalence rate of 335) have 20 times more cases than White women (who have a prevalence rate of 17).

Disproportionate Impact
According to 2010 Census estimates found in the *October 2012 Quarterly HIV/AIDS Analysis*, Michigan's general population is 77% White (non-Hispanic) and only 14% Black, but among

residents living with HIV or AIDS, 58% are Black and only 34% are White. The HIV/AIDS prevalence rate per 100,000 for Blacks is 632 compared to 149 for Hispanics and 67 for Whites. (In other words, the prevalence rate for Blacks is more than nine times higher than for Whites).

The *October 2012 Quarterly HIV/AIDS Analysis* reports that Black males in Michigan have both the highest prevalence rate 960 per 100,000 and also the highest number (6,308) of PLWH/A. Black females have the second highest prevalence rate (335) and the third highest number of cases (2,433). Hispanic males have the third highest prevalence rate (228) and the fifth highest number (506) of cases, a high impact on a relatively small demographic group. White males have the second highest number of cases (4,447) and a prevalence rate of 119. Put another way, these data tell us that Black males have eight times more cases than White males in the same size population (100,000), and Hispanic males have twice as many as White males. Among females, Black women (with a prevalence rate of 335) have 20 times more cases than White women (who have a prevalence rate of 17).

There are an estimated 19,300 people living with HIV in the state of Michigan, of whom 22% (4310) are women and 17% (3820) are youth. Michigan's number of women, infant, children and youth (WICY) reported to be living with HIV has grown by nearly 10% between 2008 and 2010. While the majority of WICY living with HIV in Michigan are women ages 25 years and older (76%), the number of youth ages 13-24 has continued to increase, with youth making up over 60% of new WICY diagnoses between 2008 and 2010. Michigan's epidemic is characterized by high rates of HIV infection among Black males (55.4%) and females (15.5%), MSM (50%), youth (particularly youth ages 20-24 at 22.8%) and southeastern Michigan residents (12.5%).

The *January 2012 Quarterly HIV/AIDS Analysis* reports that Black males in Michigan have both the highest prevalence rate 941 per 100,000 population and also the highest number (6,186) of PLWH/A. Black females have the second highest prevalence rate (333) and the third highest number of cases (2,417). Hispanic males have the third highest prevalence rate (225) and the fifth highest number (499) of cases, a high impact on a relatively small demographic group. White males have the second highest number of cases (4,433) and a prevalence rate of 119. Put another way, these data tell us that Black males have eight times more cases than White males in the same size population (100,000), and Hispanic males have twice as many as White males. Among females, Black women (with a prevalence rate of 333) have 20 times more cases than White women (who have a prevalence rate of 17).

Michigan residents with HIV infection continue to be predominantly MSM persons who are Black, persons aged 20-39 years at the time of HIV diagnosis, and/or residents of southeast Michigan. The number of new HIV diagnoses per year between 2006 and 2010 remained stable in Black and White MSM. This is the first time Black MSM has not showed a significant increase in five consecutive trend reports. The number of new diagnosis in injection drug users decreased significantly (average 12% per year) for the seventh consecutive report. The proportion with heterosexually acquired infection is now greater than the proportion infected through injection drug use, although these two groups are closely intertwined. The number of persons aged 13-19 years at the time of HIV diagnosis did not significantly increase between 2006 and 2010 for the first report in six trend reports; however, new diagnoses in persons aged

20-29 years during this time period did significantly increase. Clearly the impact of the HIV epidemic disproportionately affects racial, ethnic and sexual minority populations in the State.

The Impact of Co-Morbidities

A growing emphasis on the need for integration of HIV, STI, TB and hepatitis testing, programs, and services is shared by the CDC and RW Parts B and D grantee and DHWDC. It has been documented in the literature that co-morbidities and numerous chronic conditions correlate with high health care costs and add to the complexity of providing care to people with HIV and others with chronic illnesses. Instead of treating one disease or social issue, several must be addressed, thereby increasing the cost of care, depending on the co-morbidities. Most PLWH/A with co-morbidities use multiple medications so the potential for drug interactions is greater and they may experience greater difficulty with adherence to drug regimes. Additionally, due to co-morbidities, PLWH/A may experience increased rates of depression, mental illness, substance abuse, and an array of other conditions. Co-morbidities are often associated with adverse health outcomes, poor quality of life, and increased health care use and related expenditures (The University of Medicine and Dentistry of New Jersey).

Sexually Transmitted Infections (STIs*)*

Syphilis rates among PLWH/A were significantly higher than those in the general population. In 2011, there were 276 reported cases of syphilis among PLWH/A, 128 of which were infectious syphilis. The infectious syphilis rate among PLWH/A was 870 per 100,000. Thirty-seven percent of all syphilis cases and 47% of male syphilis cases were co-infected. Of PLWH/A with syphilis, 8 were 15-19 years old (2.8%), 51 were 20-24 (18%), 44 were 25-29 (16%), 74 were 30-39 (27%), 72 were 40-49 (26%) and 27 were older than 50 (10%) (Epidemiology, MDCH, DHWDC, 2011). The rates of co-infection vary significantly by county. Thirty-seven percent of people with syphilis in Detroit were co-infected with HIV, and there were also high levels of co-infections in Kent County (46%), Ingham County (47%), Macomb County (41%), Oakland County (45%), and Outer-Wayne County (70%). Seventy-one percent of the co-infected cases were African American. There were 259 cases of documented gonorrhea among PLWH/A in 2011. The rate of gonorrhea in 2011 among those with HIV/AIDS was 1,760 per 100,000 or over 13 times the rate in the general population. Only 35 of the cases were female and 24 of the cases were White. Eighty-six percent of cases were males and almost 59% were African American. Sixty percent of the co-infected cases were from Detroit City, 15% were from Oakland County, and 6% were from Outer-Wayne County. Sixty-seven percent of the PLWH/A who also had gonorrhea in 2011 only had gonorrhea once while 33% had one or more gonorrhea cases in that timeframe.

Rates for gonorrhea and chlamydia were higher, at 132 and 506 per 100,000 respectively. Gonorrhea rates were highest among the younger age groups, with youth 15-19 years old at 575, followed by those 20-24 years old at 668, and those 25-29 years old at 306. The gonorrhea rate for those 30-44 years old was 98. There were 13,910 cases of gonorrhea in Michigan in 2010, a significant decrease compared to the 13,070 cases reported in 2011. Of these three STIs, the number of cases of chlamydia in Michigan in 2011 was the highest at 50,063. Similar to gonorrhea, state rates of chlamydia were highest among those 15-19 years old at 2,627, followed by those 20-24 years old at 2,821, and those 25-29 years old at 1,022. A large racial disparity

exists with gonorrhea and chlamydia. For gonorrhea the rate among African Americans is 25 times the White rate and for chlamydia it is 9 times the White rate.

Hepatitis

Hepatitis C (HCV) was the most common co-infection among PLWH/A during the Adult and Adolescent Spectrum of Disease (ASD) study in 2001 – 2003. Of the 1,790 persons in care and in the ASD, 353 (20%) had a diagnosis of HCV at some time during ASD follow-up, while 207 (12%) had a diagnosis of hepatitis B and 64 (4%) had a diagnosis of hepatitis A. More recent data is currently being analyzed and will be included in the *2012 Profiles of HIV in Michigan*, scheduled to be published in July 2012.

The Hepatitis C Advisory Task Force, whose responsibility is to advise MDCH on hepatitis-related issues, has cited that individuals infected with HIV, who then become infected with hepatitis C, are less likely to spontaneously clear the hepatitis virus. Rates of 15% to 25% of mono-infected versus 5% to 10% of co-infected. HIV complicates
hepatitis C diagnosis due to higher rates of false negative screening tests. The Task Force recommends that hepatitis C screening and testing be integrated into existing programming that provides services to individuals with, or at risk for HIV and STIs, with hepatitis testing being offered to all HIV infected individuals and individuals with other STIs being screened for hepatitis C risk factors and offered testing, if at risk.

Michigan's Unmet Need Framework

MDCH uses two data sources to produce the numbers in the Unmet Need Framework. The first source is eHARS (enhanced HIV/AIDS Reporting System), the surveillance database that contains information on all reported cases of HIV/AIDS in Michigan. Both HIV and AIDS are notifiable conditions in Michigan, so both are included in eHARS. The second source is the laboratory database. Michigan implemented mandatory laboratory reporting on April 1, 2005 for positive diagnostic HIV tests and July 1, 2005 for all HIV viral load (VL) and all CD4 tests. These laboratory results are contained in a Microsoft Access database maintained by the HIV Surveillance Program. Primary Medical Care was defined as having a laboratory result for a CD4 count and/or percent or a VL measure during a 12-month time period (October 1, 2009 through September 30, 2010) among patients in eHARS. These external laboratory results were then joined to eHARS surveillance data and were used to determine each patient's most recent CD4 count, CD4 percent, and/or VL test date. Persons diagnosed on or after October 1, 2009 were excluded from analysis to eliminate the possibility of including those who were very recently diagnosed and had not yet obtained care. Unmet need was calculated by determining the number of persons in eHARS who were diagnosed before October 1, 2009 and had not received a VL or CD4 test between

October 1, 2009 and September 30, 2010. Unmet need data contained in Table 1 show that in Michigan 36% of PLWH/A who know their status is not receiving regular HIV-related primary medical care.

While the combination of laboratory and surveillance data offers an ideal way to measure unmet need, there are some limitations to the data that should be noted. Persons who move out of state will automatically be counted as unmet need cases if Michigan's HIV Surveillance Program is not notified of the changes in residency. The Surveillance Program participates in Routine

Interstate Duplicate Review (RIDR), in which Michigan collaborates with other states under the guidance of the CDC and Prevention to assess and resolve potential case matches between the states. This effort minimizes the effect of residency on unmet need. Similarly, if a person died and Surveillance was not notified, that person would be counted as an unmet need case. Michigan's HIV Surveillance Program conducts a death match annually to prevent this from happening. Finally, there inevitably is room for error in the laboratory reporting system. For example, cases can potentially be falsely matched or non-matched to the surveillance database. Overall, however, the laboratory reporting system is strong and checks are in place to ensure the quality of those data. See **Table 1** below for details.

Table 1 Current residence of persons with met need compared to persons with unmet need, Michigan, as of November 2011

Current residence	Met need			Unmet need			Total		Percent unmet need
	n	(%)		n	(%)		n	(%)	
Detroit MSA	6167	(64%)		3379	(61%)		9,546	(63%)	35%
Outstate MSAs see below	3,498	(36%)		2,152	(39%)		5,650	(37%)	38%
Ann Arbor	*392*	*(4%)*		*192*	*(3%)*		*584*	*(4%)*	*33%*
Benton	*132*	*(1%)*		*112*	*(2%)*		*244*	*(2%)*	*46%*
Flint	*302*	*(3%)*		229	*(4%)*		*531*	*(3%)*	*43%*
Grand Rapids	*834*	*(9%)*		466	*(8%)*		*1,300*	*(9%)*	*36%*
Jackson	*143*	*(1%)*		102	*(2%)*		*245*	*(2%)*	*42%*
Kalamazoo–Battle Creek	*292*	*(3%)*		168	*(3%)*		*460*	*(3%)*	*37%*
Lansing–East Lansing MSA	*363*	*(4%)*		197	*(4%)*		*560*	*(4%)*	*35%*
Saginaw–Bay City–Midland	*193*	*(2%)*		135	*(2%)*		*328*	*(2%)*	*41%*
All other rural counties	*585*	*(6%)*		*352*	*(6%)*		*937*	*(6%)*	*38%*
Other/Unknown	262	(3%)		199	(4%)		461	(3%)	43%
Total	9,665	(100%)		5,531	(100%)		15,196	(100%)	36%

Unmet Need- There are currently 5,531 HIV positive persons, or 36%, not receiving the specified HIV primary medical care in Michigan. The majority of PLWH/A, whether with met or unmet need, is Black, non-Hispanic (57%) or White, non-Hispanic (36%). Hispanic persons represent only (5%) of all PLWH/A in Michigan, but they have the highest proportion of unmet need (50%) when looking at race/ethnicity.

The unmet need distribution by sex is 78% male and 22% female. It is the same among persons with met need and among all persons with HIV/AIDS, so there does not appear to be a

disproportionate level of unmet need by sex. As of November 2010, both sexes report the same percentage of unmet need (38% among males and 38% among females).

Individuals living with HIV/not AIDS in Michigan continue to be more likely to have unmet need than people living with AIDS. People living with HIV/not AIDS are 42% of the total HIV/AIDS aware population, but only 38% of the total in care. In other words, 44% of people living with HIV/not AIDS have unmet need, while only 32% of people living with AIDS have unmet need.
Persons with unmet need are very similar to persons with met need when comparing age at HIV diagnosis. PLWH/A who were young adults (ages 20-24) at HIV diagnosis have a higher proportion of unmet need when compared to other age groups (42%), followed by adults ages 25-29 (41%). In general, unmet need is higher among the younger age groups than among those aged 35 or more. By risk behavior, injecting drug users have the highest percentage of unmet need (50%), while only 35% of MSM are in the unmet need group.

An analysis of data for women, infants, children and youth (WICY) specific unmet need in Michigan shows 36% overall unmet need among WICY, which is consistent with the overall state percentage. Among WICY, unmet need is highest among women ages 25 years and older (37%), followed by youth ages 13-24 years (30%), and children ages 2-12 years (22%). Percentage of unmet need for infants in Michigan is zero.

Taken together, Michigan epidemiologic data demonstrate a continued need for services to women, an increasing need for services to youth, as well as a continued measure of services to infants and children in Michigan.

Current HIV Services
The MDCH, DHWDC, continues to build upon and improve the existing HIV services, which strives to meet the needs of all PLWH/A, ensuring full and equal access to high quality, culturally competent care. MDCH's commitment is to decrease the number of new infections, increase the number of people who know their HIV status, encourage early entry into care following diagnosis, and preserve and maintain the health of individuals currently in care.

MDCH has recently made a number of very successful changes in the system of care to better meet the needs, with a special emphasis on rapid linkage to and retention in care for both newly diagnosed individuals and PLWH/A who have been out of care. These changes include:

- Establishing a statewide quality management program through the Michigan Cross Parts Quality Collaborative (MCPQC)
- Recruiting, training and using peers as a key strategy to help increase entry and retention of PLWH/A in the HIV care system
- Using Early Intervention Services to link PLWH/A to care
- Improving provider coordination, community partnerships, availability and accessibility of HIV services and other information, and program design and policies to increase access to and retention in HIV care
- Collaboration with Midwest AIDS Training and Education Center (MATEC), which conducts targeted, multidisciplinary education and training programs for health care providers

- The Detroit Eligible Metropolitan Area (DEMA) has created a number of integrated programs to keep people in care

Michigan revised its HIV Counseling and Testing policy in 2008 to allow universal diagnostic screening for HIV with an opt-out clause. Medical providers must arrange an appointment for medical care for individuals who test positive. Regional anonymous and/or confidential HIV Counseling and Testing programs are available at local health departments (LHD) on a walk-in or scheduled appointment basis with some evening availability.

All HIV testing services supported by the Division emphasize sexual and racial/ethnic minority populations and other historically underserved populations. Community-based organizations supported for provision of highly-targeted testing must demonstrate capacity and success in accessing priority populations. Resources supporting testing in clinical settings are concentrated in geographic areas with high HIV prevalence, most notably Detroit, and in venues which serve high-risk populations, such as STI clinics. As a result of this approach, we have successfully addressed racial/ethnic and sexual minority communities. In 2010, of the nearly 85,000 tests conducted in public sites in Michigan, 61% were for African Americans and 4% were Hispanic. Of all of the new diagnoses, 70% were MSM.

Michigan is divided into 45 local health departments (LHDs) that provide clinical services for family planning, STI screening and treatment, maternal and child health, special health care services for children, nutrition programs, and immunizations. Services also include sanitation, environmental monitoring, and epidemiologic investigations. Many LHDs provide HIV counseling, testing, and referral services.

The current continuum of care encompasses counseling, testing, and referral; linkage to care, as well as a wide range of core support services at a number of sites throughout Michigan, including the Michigan Department of Corrections (MDOC).

Once tested positive, a PLWH/A is linked to care, through counseling and testing sites, medical case management and peer navigation. Once linked to care, a PLWH/A has access to many of the core and support services described below.

- Outpatient/Ambulatory medical care
- AIDS pharmaceutical assistance
- Oral health (dental)
- Early intervention services
- Health insurance premium and cost sharing assistance
- Home health care
- Home and community-based health services
- Hospice services
- Mental health services
- Medical nutrition therapy
- Medical case management
- Substance abuse outpatient
- Non-medical case management

- Emergency financial assistance
- Housing related supportive services
- Adherence counseling
- Psychosocial counseling

See below a description of core services provided for Michigan clients in 2011.

Ryan White funded Core Services in Michigan

The RW Comprehensive AIDS Resources Emergency (CARE) Act, was first enacted in 1990 to provide federal funds to help communities and States increase the availability of health care and supportive services for PLWH/A. In 2006 the CARE Act was replaced by the Ryan White HIV/AIDS Treatment Modernization Act which was reauthorized in 2009 as the Ryan White Treatment Extension Act. Under this legislation, Part A funds are allocated to Eligible Metropolitan Areas heavily impacted by the epidemic (e.g., the Detroit EMA). Ryan White Part B funding, including the AIDS Drug Assistance Program (ADAP) earmark, provides grants to States and U.S. Territories, to fund core medical services and support services for people living with HIV/AIDS. Part C resources fund outpatient HIV early intervention services at local health care facilities and clinics, and Part D is used to coordinate and enhance services for women, infants, children and youth. RW HIV/AIDS Program resources are funds of last resort. Michigan receives approximately 30 million dollars in Ryan White funding.

The services supported by RW funds vary by jurisdiction, but include health care services such as out-patient ambulatory medical care, medications, medical case management, mental health services, and supportive services, such as transportation, that link PLWH/A to care. MDCH is the Grantee for the Part B, ADAP and the Part D resources allocated to Michigan. The City of Detroit Department of Health and Wellness Promotion (DHWP) is the Part A Grantee designee. There are four Part C funded programs in Michigan: Wayne State University's Adult HIV/AIDS Clinic at the Detroit Medical Center, the Detroit Community Health Connection, the University of Michigan's HIV/AIDS Treatment Program in Ann Arbor, and Saint Mary's Health Care Special Immunology Services in Grand Rapids.

Data Collection

The Uniform Reporting System (URS) is a statewide client-level data standard designed to consistently document the quantity and types of services provided by agencies receiving RW funds, and describe the populations receiving the services. Statewide URS data show that in 2011, 5,683 unduplicated clients received core medical services of which 4,228 received medical case management and 3,512 received services through ADAP. See **Table 2** below**.**

Current Data Collection System

There are currently four separate CAREWare databases. The MDCH CAREWare system includes all the Part B and Part D funded programs as well as data from two Part C funded programs and from programs funded through Michigan Health Initiative (MHI). DHWP maintains another CAREWare database for Part A funded programs. MCDH and DHWP have each implemented CAREWare as a centralized database accessed by service providers through a secure internet portal. Two Part C Programs, the University of Michigan and the Detroit Community Health Connection each maintain their own individual CAREWare systems. Clients

and services from the ADAP and the Michigan Dental Program (MDP) are imported into the MDCH CAREWare database from other data systems on a regular basis.

Table 2	Outpatient Medical Care	Oral Health Care	Mental Health Care	Medical Case Management	DAP (Medication Assistance)
No. of providers supplying valid data*	23	8	13	19	1
No. of unduplicated clients served**	5,683	702	724	4,228	3,512
Percent receiving the service.	78.00%	9.60%	10.00 %	58.00%	48.20%
Total Days of Service***	25,342	2,784	4,626	74,237	75,335
Average no. of visits per client	4.8	3.9	4.4	18.1	32.5
Median no. of visits per client	4	3	2	11	25
Range of visits per client	Jan-47	Jan-45	Jan-51	1-286	1-231
* A provider may be included in more than 1 service category					
** Clients are unduplicated for the service across all providers and may be counted in more than one service category.					
*** The Drug Assistance service unit is a prescription filled rather than a visit or day of service.					

The Impact of Budget Cuts on the HIV/AIDS Service System

The impact of federal, state and local budget cuts have contributed to continuous erosion of the health care system, and have placed additional burden on the HIV prevention and care continuum in Michigan.

Michigan is one of the ten states that, since 2007, has implemented extensive revenue-raising measures. The State of Michigan cut public health services, services to the elderly and disabled, K-12 and early education and higher education funds, as well as State workforce funds. The State of Michigan:

- Ended a medical coverage program for 950 adults with dependent children unable to afford employer-sponsored health insurance after transitioning from welfare to work
- Dropped coverage of dental and/or vision services for adult Medicaid recipients

- Froze enrollment for long-term care services and supports that help the developmentally disabled avoid institutionalization. Some 300 people were placed on a waiting list
- Reduced by 38% funding for No Worker Left Behind, a job training and education grant program administered through the Department of Labor
- Imposed furloughs and/or pay cuts for State employees
- Established hiring freezes and/or laid off or announced plans to lay off State employees

Following the State's requirements, some of the cuts were implemented on the local level causing reductions in funds and services for child care assistance, meals for the elderly, hospice care, services for veterans and seniors, and others.

Many of the services previously provided by state or local government programs and/or community-based organizations are now no longer available to PLWH/A or are available to a lesser extent. The MDCH is working to preserve as many of the essential services as possible.

The hardship experienced by PLWH/A is often intensified by housing foreclosure or job loss. PLWH/A frequently need assistance with first- or last-month or past-due rent payments and security deposits in order to secure their housing and remain in care.

Michigan's hospitals have been laying personnel off since 2008. The hospitals continue to lose revenue due to the increasing number of unemployed and uninsured/underinsured patients. Given the existing shortage of medical personnel, lay-offs of hospital personnel intensify patients' inability to access care. Another factor increasing difficulty to access care is that there are fewer and fewer numbers of specialists willing to accept Medicaid rates. The MDCH, DHWDC is working to engage some FQHCs to assist with the need for medical services.

In the past few years, enrollment into the Michigan Medicaid program has increased by 20%. The Medicaid system is growing overburdened. Medicaid adult dental benefits were cut in 2009. To meet the challenge, MDCH, DHWDC has been allocating increased funding to oral health services since 2010.

State-level HIV/AIDS prevention funding experienced a dramatic cut in 2011, to be followed by further reductions. Some local health departments (LHDs) have difficulty providing consistent health services due to lack of funding. Education and testing funds are also insufficient. In response, MDCH, DHWDC is integrating services at the state and local level to ensure that providers effectively partner with prevention programs to identify, refer, link and retain newly diagnosed clients in the care process.

Priority Prevention Populations

Michigan's priority populations, their HIV prevention needs and recommendations for intervention strategies best suited to meet those needs are the product of a close collaboration between the MHAC and the MDCH. As previously stated, MHAC membership includes persons living with HIV/AIDS, representatives of affected communities, local public health, community-based organizations, stakeholders and individuals with relevant expertise.

MDCH will use this *Plan* in determining program and resource allocation decisions associated with the support of HIV efforts throughout the state. MHAC is responsible for sustaining the Plan by advising MDCH on associated implementation activities, monitoring compliance with the Plan, and advancing effective HIV/AIDS policy.

Prioritized Populations, Prevention Needs and Interventions

The Prevention Plan Workgroup (PPW) used an evidence-based, data-driven process to prioritize populations, identify prevention needs and match them to interventions. Each step was voted on by the PPW, and then presented to and voted on by the full body of MHAC. Through the evidence-based process four populations were prioritized and are listed below by rank:

1. **HIV-positive persons**

HIV-infected individuals who are at risk of transmitting HIV, or contracting sexually transmitted diseases, hepatitis C or B as a result of continued unprotected sex and/or sharing of drug use paraphernalia.

2. **Men who have sex with men (MSM)**

Includes all men having sexual contact with other men, regardless of self-identification. Men who have sex with both men and women (i.e., behaviorally bisexual men) and MSM who are also injecting drug users (i.e., MSM/IDU) are included in this category.

3. **Injection drug users (IDU)**

Includes persons who inject drugs by needle into a vein, under the skin or into muscle.

4. **High risk heterosexuals (HRH)**

Individuals who are at increased risk for becoming infected with HIV by virtue of opposite-gender sexual contact. This includes:

a. Sex partners of HIV-positive persons
b. Sex partners of injection drug users
c. Female sex partners of men who have sex with men
d. Individuals with a sexually transmitted infection
e. Commercial sex workers
f. Individuals who provide sex for drugs/money

Description of Need

<u>Prevention</u>

In the context of HIV prevention, a "need" refers to a psychosocial or environmental factor that influences an individual's behavior. Needs are sometimes referred to as "determinants of risk." Addressing HIV prevention needs assists an individual initiating or sustaining behavior that will reduce their risk for transmission and/or acquisition of HIV.

A need is not an intervention. Often "needs" are articulated in terms of interventions: "Population X needs street outreach." While street outreach may be an appropriate strategy for

addressing the prevention needs of population X, the true prevention need may be for accurate knowledge of HIV transmission modes.

In Michigan, needs are grouped into five broad categories: knowledge, persuasion, skills, access and supportive norms. A person may have one prevention need or several. Often needs must be addressed incrementally. For example, trying to build someone's skills to use a condom will be less likely to succeed as a prevention strategy unless that person also understands and accepts that condoms are an effective method for preventing transmission/acquisition of HIV.

Below each category of need is explained in further detail:

Knowledge: Individuals have a knowledge-related need when they have inadequate or incorrect information about HIV (e.g., routes of transmission).

Persuasion: Individuals have a persuasion-related need when they have accurate and complete knowledge about HIV but do not or cannot act on that knowledge. Persuasion-related needs often refer to how someone feels about behaviors (e.g., I hate using condoms, they just don't feel good).

Skills: Individuals have skills-related needs when they are unable to discuss or implement risk reduction strategies (e.g., I don't know how to talk to my partner about safer sex).

Access: Individuals have access related needs when they have difficulty obtaining materials, tools and/or services. Access refers to the practical matter of obtaining materials (brochures, syringes), or supportive services (HIV counseling and testing). Access also encompasses the cultural, linguistic, and developmental competence of prevention materials, tools and services.

Supportive Norms: Individuals have the need for more supportive community norms when an individual is unable to initiate or sustain safer behaviors because other people in their community do not value those behaviors.

HIV Prevention Intervention Definitions

- **Counseling, Testing and Referral:** An interactive process whereby clients are assisted in identifying the specific behaviors and context of those behaviors which place them at increased risk for acquiring or transmitting HIV. The process also assists a client in identifying and committing to specific strategies designed to reduce the risk for HIV transmission or acquisition. Also includes test decision counseling, antibody testing and result delivery and referral to supportive services.

- **Partner Services:** Elicitation of sex and needle sharing partners of HIV infected individuals and notification of those partners of their exposure; followed by offering of HIV prevention services, including HIV counseling, testing, and referral.

- **Individual Level Prevention Counseling:** Multi-session health education and risk reduction counseling provided to one individual at a time. The focus of this intervention is to assess risk reduction needs of clients and assist them in making plans for individual behavior change. This intervention must include risk assessment and development of a risk reduction

plan. Can also assist clients in obtaining referrals to other prevention services in clinical and community settings.

- **Prevention Case Management:** An intensive and ongoing individual level intervention targeting clients with multiple, complex problems and risk reduction needs. This intervention can target HIV+ individuals or HIV- clients at high risk for HIV and is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition or transmission. Provides intensive, ongoing, individualized prevention counseling, support, and referral assistance.

- **Skills Building Workshop:** An intervention this is provided to a small group that focuses on helping participants develop or enhance specific skills to engage in risk reduction practices. It must include client demonstration of skill by all participants. Examples of skills building topics include condom use, safer needle use, negotiation skills, etc.

- **Informational Session:** One-time, information only, group presentation covering topics such as HIV/AIDS, viral hepatitis or sexually transmitted diseases. Information may include definitions, statistics, trends, transmission, prevention, disease symptoms and progression, and testing. Although the presenter may demonstrate a skill (e.g., how to put on a condom), this intervention does NOT include a skills building component because clients do not practice the skill.

- **Outreach:** HIV/AIDS educational intervention conducted face-to-face with clients outside more traditional institutional settings, in their own neighborhoods or other areas where they socialize or congregate. Outreach must include verbal exchange of information between provider and client. Materials distribution alone does not constitute outreach.

- **Community[1] Level Interventions:** Interventions that seek to change the attitudes, norms, and behaviors of entire communities. These approaches recognize that local values, norms, and behavior patterns have a significant effect on shaping an individual's attitudes and behaviors. Community level interventions may include several components. For example, the MPowerment intervention includes formal and informal outreach, skills building workshops, and small media campaigns.

- **Structural Interventions:** This intervention aims to modify social, economic and political systems, and may affect legislation, media, health care and the market place. Structural interventions can directly alter the physical environments in which people live, work, play, and have sex, to help reduce risk. Changing a paraphernalia law to allow access to sterile syringes is an example of a structural intervention.

- **Health Communications:** Use of communication strategies to inform and influence individual and community decisions that enhance health. Effective strategies combine theories, frameworks and approaches from behavioral sciences, communication, social marketing and health education. Health Communications are typically delivered through a

[1] The term community has multiple meanings. This document reflects the work of the Prevention Plan Workgroup (PPW) and consequently their use of the term. In the course of their work, the term was used to refer to groups of individuals that share risk behaviors or serostatus (i.e., HIV-positive persons).

variety of media outlets. Examples include billboards, radio and television public service announcements.

Care

Individuals in Michigan who have unmet need tend to be: people with HIV/non-AIDS, those in younger age groups at time of diagnosis, and those living in certain out-state geographic areas, including Benton Harbor, Flint, Jackson County, and Saginaw-Bay City. Although there are few needs assessment data available for individuals not in care, we may be able to make the assumption that based on the definition of unmet need, their service needs include medical care and appropriate laboratory testing.

Service needs identified through Michigan's most recent needs assessment of those in care (February 2010) include dental care, support group services and assistance in meeting basic needs, e.g., rent/mortgage and emergency financial assistance. Barriers to receiving services, experienced by those not in care, may include: affordability, concerns about confidentiality, stigma or quality of care, or lack of awareness of services and how to obtain them.

While in the past, MDCH has conducted its own Continuum of Care Needs Assessment and Service Utilization Analysis, resource constraints have necessitated consideration of other available data sources. MDCH will now work together with the Medical Monitoring Project (MMP) to obtain data on the needs and barriers faced by those in care to complement unmet need data. The MMP conducts both medical chart abstractions and qualitative interviews with a representative population-based sample of people living with HIV to describe characteristics and trends, utilization of services and unmet need, and plan for improved prevention and care services.

The 2009 MMP data summary shows that 43% of patients sampled utilized auxiliary services. The most commonly used services were education sessions (77%), case management (44%), and mental health counseling or treatment (29%). For the 29% of patients with documented referrals, the most common referrals were for mental health services (51%), case management (30%), and food and housing support services (16%). Individuals not in care may have similar, but perhaps a greater magnitude of, need in these areas.

The Michigan HIV/AIDS Strategy Summit held in October 2011 was specifically crafted to allow the state of Michigan to respond to the National HIV/AIDS Strategy by gathering community input and recommendations for implementation, as well as provided information that could be utilized in the CDC Prevention FY2012 funding opportunity announcement. This event also provided an environment to provide strategies for achieving health equity in Michigan, with particular attention to racial, ethnic, and sexual minority populations, and prioritizing these recommendations for the National Partnership for Action to End Health Disparities campaign. The MDCH, DHWDC Summit Summary can be found in **Attachment 3**.

This one-day summit consisted of two national speakers, who discussed the ramifications and the implementation of the National HIV/AIDS Strategy, as well as the importance of stakeholder involvement in National Partnership for Action to End Health Disparities. There were three breakout sessions held for discussion and recommendations on the major goals of the National HIV/AIDS Strategy: 1) Reducing new HIV infections; 2) Increasing access to care and improving health outcomes for people living with HIV; and 3) Reducing HIV-related health disparities.

The audience included staff; DHWDC contracted agencies working in sexually transmitted disease prevention and treatment; HIV prevention; counseling and testing; case management; and substance abuse treatment. Participants also in attendance included representatives from local public health departments (STI clinics, TB clinics, HIV programs, and family planning programs); clinical care providers; community-based organizations (HIV prevention and counseling and testing); AIDS service organizations; health disparities organizations and health equity programs; people living with HIV/AIDS; MATEC, MDCH training staff, and community stakeholders. A total of 224 individuals attended this one-day event.

The following goals and objectives were created by Summit participants:

- Linkage to Care: Increase by 65% to 80% the number of individuals newly diagnosed with HIV who are successfully linked to care and treatment for HIV disease within three months of diagnosis.
- Retention in Care: Increase by 5% the number of PLWH/A that remains in medical care.
- Secondary Prevention: Increase by 30% the number of HIV infected clients reported in CAREWare that are tested at recommended intervals for STIs.
- Progress and Quality: Increase by 25% the quality of care for HIV infected individuals based on the five quality indicators collected by the DHWDC.
- Increase the Number and Diversity of Providers: by 2015, increase the number of Federally Qualified Health Centers that provide prevention, primary care and treatment for people living with HIV.
- Reduce Disparities and Viral Loads: Work to assure that the care and prevention needs of racial, ethnic and sexual minorities are met in a rapidly changing environment with emphasis on HIV, STIs and hepatitis C.
- Routinized Perinatal Testing: Increase by 5% the number of pregnant women being routinely tested for HIV and syphilis during pregnancy.
- Intensify HIV Prevention Efforts in Communities where HIV is most heavily impacted. By 2015, decrease the number of new STIs, HIV and hepatitis C infections.
- Expand targeted efforts to prevent HIV infections using a combination of effective, evidenced-based approaches. By 2015, increase targeting in public-supported HIV and STI prevention, testing and treatment sites to the population most affected by these diseases.
- Educate all Americans about the threat of HIV and how to Prevention HIV. Increase by 10 percentage points the number of individuals ages 18-64 who know their HIV status, as measured by the Behavioral Risk Factor Surveillance System.

- Achieve a more coordinated "National Response" to the HIV epidemic: By 2015, increase organizational capacity and engagement of internal and external partners to address health equity.
- Intensify HIV Prevention Efforts in the Communities Where HIV is Most Heavily Concentrated: By 2015, increase targeting in public-supported HIV and STI prevention, testing and treatment sites to the population most affected by these diseases.
- Ensure that high risk groups have access to regular viral load and CD4 tests, and reduce HIV-related mortality in communities at high risk for HIV infection. Facilitate systems change necessary to improve the health status of impacted communities, with emphasis on racial and ethnic and sexual minorities.
- Promote a more holistic approach to health, and adopt community-level approaches to reduce HIV infections in high risk communities. By 2015, improve access to equitable, quality healthcare.

PLWH/A Identified Needs

MDCH, COC conducted an assessment of the care and service needs of Michigan residents living with HIV/AIDS In 2010. This statewide assessment continues to inform funding priorities outlined in the COC Request for Proposals (RFPs) and to guide COC Program funding distribution throughout the state to ensure comprehensive, coordinated, culturally-competent and quality HIV/AIDS care services for Michigan residents living with HIV/AIDS.

Two data collection methods were used to inform the 2010 assessment. A needs assessment survey was distributed to PLWH/A, of which 971 valid surveys were complete and returned. Targeted focus groups were conducted to further understand and highlight the care and service needs of two priority populations of PLWH/A who reside in the Detroit Eligible Metropolitan Area (DEMA): young African American MSM and recently incarcerated individuals.

Michigan's outstate areas, organized into eight regions, comprise the focus of this report. Outstate Michigan is defined as all geographic areas in Michigan, excluding the DEMA. See the Detroit Eligible Metropolitan Area, HIV/AIDS Comprehensive Plan 2012–2014, Southeastern Michigan HIV/AIDS Council for a comprehensive description of needs, gaps and barriers in the EMA (**Attachment 1)**.

Approximately 50% of survey respondents were outstate area residents (482/971). Among outstate respondents, 81% were male (389/482); 16%, female (79/482); and 2 individuals were transgender. Respondents were: predominantly white (74%); followed by African American (15%), Hispanic (5%) and African National (4%). Respondents ranged in age from nineteen to ninety-two years old. Thirty-two percent had an AIDS diagnosis.

The most common care priorities reported by outstate respondents were 1) cost of services, 2) confidentiality, and 3) quality of services. Similarly, for respondents reporting a lapse in care, not being able to afford care, confidentiality, and stigma/judgment or ill treatment by a provider were among common reasons. The most common unmet need reported by respondents was dental care, with 23% of outstate respondents (112/482) reporting needing and not being able to get dental care services. Other common unmet needs for outstate residents were 1) support group and buddy/companion services, and 2) resources to meet basic needs (e.g. help paying rent/mortgage and emergency financial assistance).

Participants' number one recommendation for what agencies can do to better serve them was "know what HIV-related services are available and provide referrals to them." Also of note is that several participants across the regions indicated that income-levels for programs requiring low-income eligibility for services are often set too low, leaving some ineligible for low-cost or free services and unable to pay regular fees for services. Additional needs include access to care and treatment, transportation, public assistance, competent care, culturally appropriate care and services, community support through support groups or buddy support. Barriers identified were stigma, access to resources, lack of knowledge, lack of support, mental health and substance abuse issues, depression, isolation, continued unprotected sex, feelings of low self- worth and guilt.

The most important gaps and needs for the populations who are unaware of their HIV status, include more accessible testing sites, culturally competent services, availability of non-judgmental providers, counseling and support to encourage safe sex, HIV stigma reduction training for personnel and sterile syringe and injection programs. Also, staffs who understand poverty, stigma, and access to health care play an important part in eliminating the existing barriers, gaps, and challenges to seeking prevention and care. Barriers include mistrust of the public health system, stigma, lack of personal resource, lack of family or community support, complacency, lack of coordinated systems and difficulty accessing complicated systems.

Systems barriers include a need for improved billing and reimbursement systems, implementation of social marketing campaigns to target high risk individuals, federal, state and local requirements (10% cap on administrative services and the amount and level of reporting requirements), the ability to reduce unmet need in some areas of the state, linking people to care and keeping them in care and treatment, client adherence, services needed to reduce health disparities and resources to reduce health inequities, economic downturn, unemployment, ongoing accessible provider education, technology advances and lack of training on technology, and comprehensive and coordinated data systems.

Racial, Ethnic and Sexual Health Disparities

In Michigan, racial and ethnic minority populations experience poorer outcomes than the general population for almost every health and social condition (MDCH, DHWDC, and Health Equity Road Map 2009). In alignment with the National HIV/AIDS Strategy for the United States (NHAS), the MDCH, DHWDC, is committed to creating a state where new HIV infections are rare and when they do occur, "every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstances, will have access to high quality, life-extending care, free from stigma and discrimination." To achieve this goal, the MDCH is working to support the further development and implementation of a comprehensive HIV linkage to care system, integrating prevention and care planning and funding, and creating effective and sustained patient engagement across the continuum of care. Using the recommendations of recent linkage research (Mugavero 2011), MDCH plans to implement a statewide, coordinated approach to enhancing linkages between prevention and care services, emphasizing EIS, and peer navigation strategies.

In Michigan, as in the United States, racial and ethnic minority populations carry a disproportionately heavy burden of disease (MDCH Health Equity Road Map 2009). This burden is manifested in increased risk for disease, delayed diagnoses, inaccessible and inadequate or culturally inappropriate care, poor health outcomes and premature death, much of

which is preventable. Without a focused effort to eliminate health disparities, especially HIV, the burden of poor health on Michigan's vulnerable populations is likely to multiply, and the associated costs to the state of Michigan and the African American community will be staggering. Due to the severe reduction in Prevention funding (nearly 50%) for 2011 and forward, the goal of MDCH's Prevention and Care units to become more fully integrated, has become a necessity, in order to maintain a critical level of "test to treat" strategies that support effective linkage to care.

It has been demonstrated that individuals who are aware of their HIV status have an HIV transmission rate three to four times lower than individuals who are living with HIV, but unaware. With proposed additional HRSA and MDCH investment in the EIS, including testing, counseling, referral, and linkage to care, many new infections could be averted at a cost of only $114,000 per infection. (Holtgrave DR. Cost and Consequences of Four HIV Testing or Counseling and Testing Scenarios for the State of Michigan, 2009).

Nearly three-quarters of MDCH prevention funds are allocated to testing, both targeted and routine, in the Detroit EMA. Counseling, testing and referral and partner counseling and referral services continue to serve as a primary link between primary HIV prevention services and programs supported under the RW services. Early knowledge of serostatus and entry into appropriate care and treatment are essential to preventing and delaying the onset of HIV-related illness in individuals with HIV infection. Through the process of referral, HIV-infected individuals are linked to appropriate services, including medical care, case management, and mental health services. The Division supports the DHWP, Oakland County Health Department, and Wayne County Health Department to provide HIV testing services, nine community-based organizations and four other clinical sites. The Statewide HIV/STI information and referral hotline provides referrals to HIV testing sites. DHWDC coordinates with these and other community providers and advocates; conducting testing events around Black AIDS Awareness Day, National HIV Testing Day, National Latino AIDS Awareness Day and World AIDS Day. These events are important opportunities to raise awareness about HIV and to promote and provide access to HIV testing services for targeted populations of high-risk in their own neighborhoods and communities. Michigan's targeted early identification of individuals with HIV/AIDS (EIIHA) populations are a primary focus for these increased testing events.

With the integration of planning around Prevention and Care strategies in early 2011, several trainings have helped to shape EIS promotion of testing in the EMA and statewide. EIS workers and Peer Navigators were provided training in April and June, 2011 to focus on the need for increased HIV testing, particularly among the target groups of Young African American MSM and AAHRH, and enhanced efforts at follow-up and linkage to medical care. Peer Navigators and EIS workers have MOUs in place with high volume testing centers and are available when individuals receive results, as support and to facilitate initial engagement to medical care.

Outreach efforts have focused on connecting with private providers to encourage testing for HIV, and to raise awareness of the need to test among high-risk groups. Provider education and raising awareness of the need to test will be a major focus for Outreach during 2012-2015. DHWDC is working with the MPCA, MATEC and local providers to create a unified approach to providing HIV awareness and education in Michigan. This approach centers on the newly

launched website (www.michigan.gov/survivehiv) and media campaign described more fully in the section detailing EIIHA efforts.

Section II. WHERE DO WE NEED TO GO?

Evaluation of the 2009 Comprehensive Plan

Evaluation of the 2009-2012 Comprehensive Plan provided the foundation for the development of Michigan's statewide Quality Management Plan, created by the Michigan Cross Parts Quality Collaborative (MCPQC). The MCPQC's Quality Management Plan focuses on identified quality indicators, capacity development training and revision of standards of services to assure consistent, quality services are available to all people living with HIV/AIDS. The 2009-2012 Comprehensive Plan accomplishments related to data collection, quality indicators, training, standards and improvements in quality services are discussed more fully later in this document.

Early Identification of Individuals with HIV/AIDS (EIIHA)

The MCPQC plays a critical role in encouraging RW funded grantees and providers to focus on enhancing linkages, retention in care, and prevention efforts across All Parts. HRSA funded Parts A-D and CDC funded Prevention grantees have collaborated in several jointly-sponsored statewide trainings to promote enhanced linkages to medical care through various strategies, such as peer navigation and EIS. CAREWare and HES data was combined to inform the FY2012 Part B application and CDC PS 10-10138 previously submitted, and a statewide plan for addressing EIIHA is currently being formulated. Within this plan, proposed cross-training of prevention and care funding systems is suggested as a strategy for increasing coordination and collaboration between Sections. An MDCH Data Management Consultant has recently been hired to facilitate and coordinate data sharing, referral, and reporting across data systems.

The critical target groups that Michigan has identified in its Early Identification of Individuals with HIV/AIDS or EIIHA Strategy intends to address are 1) Young African American Men who have Sex with Men (YAAMSM) and 2) African American High Risk Heterosexuals (AAHRH). The Parent Groups in the EIIHA Matrix have not changed substantially from our 2011 EIIHA Plan, as current data supports the continued need to address the unaware individuals in each of these groups. Blending funding streams and prevention and care strategies, enables DHWDC to address critical needs and gaps in services in high prevalence areas.

All of the strategies and efforts described above will contribute to increasing the number of clients identified, tested, and if diagnosed as HIV positive, linked to medical care—as all RW funded Parts work within the MCPQC to consolidate cross-part participation in the EIIHA, a fundamental focus of the 2012 Statewide Quality Management Plan.

Enhanced Testing Initiative

HIV testing services are supported by the Division in several ways. Sixteen of Michigan's LHDs, located in high HIV prevalence areas, are funded to provide HIV testing and PS. Testing is also provided by community-based partners who have demonstrated the ability to successfully access and engage communities most impacted by HIV, including sexual minorities and racial/ethnic minorities.

Additionally, non-governmental and community-based organizations can apply to the Division to become "designated" HIV testing sites. These organizations receive technical assistance, training, evaluation assistance, condoms, test devices and laboratory services.

The Division continues to support expansion of HIV testing in health care settings, including hospital emergency departments, jail health clinics, community health clinics and other health care settings. The Division partners with the Bureau of Substance Abuse and Addiction Services on the Early Intervention Project (EIP). The EIP targets alcohol and other drug abusers with HIV prevention (including Counseling, Testing and Referral) and EIS.

All prisoners entering any of the MDOC reception facilities are tested for HIV. Prevention counseling and PS are provided by Division staff. HIV testing is currently available to inmates of county jails in Oakland, Macomb, Jackson, Wayne, Ingham and Washtenaw Counties, which represent 6 of the 16 counties in Michigan identified as "high HIV prevalence" jurisdictions. The Division funds Wayne County jail to support provision of HIV testing, on a routine basis, to all inmates of that facility.

The Division issued RFPs for HIV prevention services in 2012 and will issue one for care services in 2013. HIV testing and other activities designed to ensure and facilitate early knowledge of serostatus and linkage to care will be prominently featured among supported activities. The COC Unit, through contracting and technical assistance, will assure that early identification of persons with HIV will continue to be a priority.

All HIV testing services supported by the Division emphasize sexual and racial/ethnic minority populations and other historically underserved populations. Community-based organizations supported for provision of highly-targeted testing must demonstrate capacity and success in accessing priority populations. Resources supporting testing in clinical settings are concentrated in geographic areas with high HIV prevalence, most notably Detroit, and in venues which serve high-risk populations, such as STI clinics. As a result of this approach, we have successfully addressed racial/ethnic and sexual minority communities. In 2010, of the nearly 85,000 tests conducted in public sites in Michigan, 61% were for African Americans and 4% were Latino. Of all of the new diagnoses, 70% were MSM.

Addressing Service Challenges

1. **Need to Reduce Stigma**

The DHWDC has found that some populations have a perceived reluctance to seek or accept HIV testing. Our needs assessment research demonstrates that younger, African American MSM in particular, express reluctance to test for HIV because of stigma and lack of knowledge regarding risk. In addition, we continue to encounter resistance from medical providers in implementing testing related to a perception that their clients are not at risk or that HIV testing cannot be easily implemented within their clinic flow. DHWDC supports a general media campaign targeted to African American communities to encourage testing. The community-mobilization campaign described previously intended to normalize HIV testing among young, African American MSM. Provider education efforts, in collaboration with the MATEC and the MPCA, are planned in 2013

to address provider concerns about barriers to testing and to encourage integration of HIV testing into routine clinical services. This community mobilization campaign is intended to normalize HIV testing among young, African American MSM.

The DHWDC launched a multi-media awareness campaign on June 1, 2012, targeting individuals with HIV who are not currently in care in four areas of Michigan with significant "unmet need": Detroit, Saginaw/Flint, Grand Rapids, and Benton Harbor. In collaboration with the DHWDC, Community Partnerships Unit and the MDCH, Media Office, the campaign was developed to target young MSM, particularly African Americans. The new campaign will employ specific messages in targeted venues along with traditional print media. The messages will ask persons to visit a new website (www.michigan.gov/survivehiv) where a variety of resources are located for easy access. The resources include a zip code search feature, where a person can identify local medical and case management resources. A Smart phone application has been developed and will be linked via banner advertisements, as well as, on Facebook and Twitter. The website went "live" on June 1, 2012 and preliminary media and marketing will be rolled out during LGBT Pride events in early June, 2012.

The RW program resources are an essential support of the DHWDC's efforts to expand routine HIV testing. RW care providers are key partners in activities designed to ensure and enhance linkage with care and prevention services. There is on-going coordination of efforts between prevention and disease control/intervention programs in regard to linking individuals unaware of their HIV positive status to medical care. The combined resources of prevention and care (via RW) in Michigan allows for a more efficient and broader administration of this program at the Division level as well as a wider coverage across the state for enhanced linkages support. It is anticipated that the synergy from these two funding efforts will yield a stronger program effort and increased program effectiveness. The maximizing of resources allows for expansion of these CDC-supported efforts into some programs that have a high yield of HIV-positive diagnosis and a relatively low yield of linkage to care.

2. Need for Accessible Testing

During 2011, DHWDC completed implementation of rapid HIV testing among all funded providers. The vast majority of HIV tests conducted by publicly supported providers are now conducted with rapid HIV tests. By ensuring that clients can obtain the results of their HIV test in one visit, rapid HIV testing also facilitates good rates of results disclosure, particularly to HIV negative clients.

3. Need for Services to Address Mental Health and Substance Abuse

PLWH/A with mental health disorders or substance abuse problems, or who are members of racial and ethnic minorities, have experienced difficulty accessing HIV health care and treatment services and achieving successful health outcomes. The AIDS mortality and morbidity in these groups continues to be higher than other populations, which is true in Michigan as well. These populations that are at high risk for HIV are also at high risk for other diseases such as diabetes, heart disease, cancer, sexually transmitted infections, hepatitis C., etc. Moreover, minorities, specifically African Americans in most areas of the state, including the Detroit and Benton Harbor MSAs, have reported numerous challenges to care including low self-esteem, psychosocial issues, stigma, isolation, incarceration, violence, ability to obtain affordable and

quality dental care, supportive services, homelessness, lack of affordable housing, employment and other basic needs. African American youth experience many of the same challenges above, but also homophobia. The MDCH, DHWDCs 2010 Needs Assessment survey revealed that many minorities were challenged by lack of transportation, high cost of services and lack of medical coverage. These challenges contribute significantly to unmet need among African Americans and African American youth.

4. Need for Integrated Care

The lifetime cost of medical care for PLWH/A adults is estimated to be $618,000 and increases with PLWH/A who have co-morbidities (viral hepatitis, STIs, mental illness, and other chronic illnesses). In FY2009, the cost of providing care to individuals through Part B, state resources and ADAP resources was $35,548,388. The total number of people served was 5,100, of which 46.1% (2,346) were African American at a total (rough) estimated cost of $163,522,258 or $6,970 per person, per year. As the number of people in need of services continue to grow, it may be necessary to implement additional cost-saving strategies for ADAP and other core and supportive services, if resources are insufficient.

5. Need for a Seamless Care and Data Collection System

A fundamental need exists in Michigan for the creation of a system in which HIV testing, prevention and treatment are linked together and the multiple data systems that support prevention and care (HES and CAREWare) are integrated to provide surveillance and client-level data analysis that can guide programming and funding decisions to support linkage of patients who have been newly diagnosed with HIV infection and retention of HIV positive patients in medical care.

6. ADAP Challenges

The December 2009 Department of Health and Human Services guidelines for antiretroviral treatment expanded the number of persons who are eligible for such medication, putting more pressure on ADAP funds and providers. In addition, state (Part B unmet need) and local (Part A unmet need) data suggest that approximately 50% of HIV positive persons estimated to be living in the Detroit EMA are either undiagnosed, or diagnosed and not in care. Therefore, there is potential demand for twice as much HIV medical care as is currently provided. HIV care providers in Michigan face the need to provide and manage antiretroviral therapy for a larger proportion of HIV positive persons and the need to manage double the number of patients accessing care, during a severe economic downturn, with level RW funding, and substantial cuts to CDC funding for Prevention. This presents a tremendous challenge.

7. Need for Enhanced Linkage System

A critical area of racial disparity is in the African American HIV positive incarcerated population within the Michigan prison system. Among those incarcerated in Michigan, 75% are African American. To effectively reduce existing HIV-related health disparities, the MDCH must focus on strengthening linkage systems and retention in care, emphasizing EIS for HIV disproportionately impacted African Americans in Michigan, especially within people who re-enter their communities and young African American males.

Michigan's plan is in alignment with the National HIV/AIDS Strategy and the MDCH, DHWDC 2011 – 2015 Strategic Plan. It also addresses the following Healthy People (HP) 2020 objectives, among others, through proposed services and objectives:

- HIV-6: Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.
- HIV-10: "Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.
- HIV-9: Increase the proportion of new HIV infections diagnosed before progression to AIDS.
- HIV-13: Increase the proportion of persons living with HIV who know their serostatus.
- HIV-14: Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.

Section III. HOW DO WE GET THERE?

This plan provides a roadmap for the Division to develop annual work plans within and across units and monitor progress towards stated goals. As a living document, the plan will be reviewed and refined as needed.

Implementation will be a shared responsibility of all staff within the Division with leads within each Section and Unit. Each unit will collect data to measure success and review progress on plan goals and strategies monthly at the unit level. Cross-unit discussion of shared goals will occur at least quarterly, as will Division-level meetings to review progress.
The Strategic Plan Work Group composed of staff from all units and levels will take responsibility for monitoring and recommending refinement and revisions. The Strategic Plan

Work Group will:

1. Review annual work plans to assure that they address key goals and strategies in the plan.
2. Specify collection of baseline and progress data.
3. Work with Division staff to support and assure that baseline and progress data on key indicators are obtained and reviewed to monitor progress towards plan goals.
4. Assure that all staff as well as Division stakeholders (Michigan HIV/AIDS Council) receive written summary report providing feedback on strategic plan progress and challenges.
5. Obtain regular input on external events and factors that need to be addressed by the Division and assess their implications for the Division and its stakeholders.
6. Recommend changes in plan strategies or indicators as appropriate, based on this review.

Needs Addressed by Intervention Types

			Needs Addressed by Interventions				
Intervention type	**Delivery Level**	**Primary Impact Level**	**Knowledge**	**Skills**	**Persuasion**	**Supportive Norms**	**Access**
Counseling, Testing and Referral Services	Individual	Individual	P[2]		P		P[3]
Individual Level Prevention Counseling	Individual	Individual		s	P		s
Prevention Case Management	Individual	Individual		s	s		P
Information Session	Group	Individual	P				
Skills Building Workshop	Group	Individual		P	s	s	
Structural Interventions	Community	Community/ Individual			s	s	P
Outreach	Individual	Individual/ Community	s				P
Partner Services	Individual	Individual	P		s		P
Health Communications	Individual/ Community	Individual/ Community	P		s	P	
Community Level Intervention	Community	Community/ Individual	s		s	P	

P= Primary need s= Secondary need

[2] For counseling, testing and referral and partner services the primary knowledge need addressed is knowledge of HIV serostatus, although basic HIV information may also be provided.
[3] For counseling, testing and referrals and partner services the primary access need addressed is linkage to care services for individuals who test HIV-positive.

General Characteristics of Interventions that Work

To be most effective, all prevention interventions must be tailored to the needs of the targeted community and to the capacities of service providers. A diverse and sustained effort is required for ongoing quality HIV prevention. An inclusive approach to prevention maintains a balanced mix of interventions and strategies to address the multifaceted and shifting needs of priority populations.

Below is a compilation of traits that support the effectiveness of interventions for priority populations

- **Include input from the targeted audience**. Members of the targeted audience should participate in the design, implementation and monitoring of interventions.

- **Responsive to a specific need**. Interventions should be implemented that address identified HIV prevention needs.

- **Provided in a culturally competent manner.** The intervention should be linguistically, culturally and developmentally appropriate for the targeted audience.

- **Target a defined audience with clear goals.**

- **Based on behavioral and social science**. With limited resources, funded interventions must be grounded in theory and practice that is known to work.

- **Include quality monitoring, evaluation and mid-course correction**. These are necessary to determine whether key intervention elements are being achieved as planned and are having the expected effect on the target population. Analysis of monitoring and evaluation should be used to correct problem areas.

- **Apply sufficient resources to implement intervention effectively.** To allow for achievement of program goals and the sufficient level of quality assurance and evaluation the program must be adequately funded.

These traits should not be thought of as an exhaustive list of principles essential to developing and running a prevention program. HIV prevention interventions can be strengthened by the use of local data to inform the development and implementation of prevention activities.

HIV-Positive Persons

Prevention Needs and Interventions

A statewide needs assessment found that a large number of HIV-positive persons noted that since learning of their HIV infection they had experienced challenges with practicing safer sex and disclosing to their sexual partners. Fifty-seven percent of HIV-positive participants reported that telling sex partners about their HIV status had been a challenge (MDCH 2001, 8). Of those currently in relationships, 23% did not know the status of their partner.

In the statewide needs assessment, 48% of respondents reported that they struggled with practicing and maintaining safer sex. Just over 50% indicated they had unprotected sex with someone who knew that the respondent was positive (Ibid., 6). Thirty-nine percent reported that they had unprotected anal or vaginal sex with someone whose HIV status they did not know. Although a significant proportion had engaged in unprotected anal and vaginal sex since learning of their infection, most believed that they have not infected anyone. Sixty-nine percent of HIV-positive persons participating in the needs assessment agreed that counseling and support to help practice safer sex is or would be helpful (Ibid., 9).

The Supplement to HIV/AIDS Surveillance (SHAS) project interviewed HIV-positive persons receiving care services at five Detroit locations. SHAS found that of the MSM respondents who had sex with a steady partner in the last 12 months, 30% had unprotected receptive anal sex and 28% had unprotected insertive anal sex (MDCH 2004, 46). Of the MSM respondents who had sex with a man other than a steady partner, 24% had unprotected receptive and 24% reported unprotected insertive anal sex (Ibid., 46).

Of the heterosexual HIV-positive women interviewed for SHAS who reported sex with a man in the last 12 months, 31% had unprotected sex with a steady male partner and 30% had unprotected sex with an other than steady partner (Ibid., 44). Of the HIV-positive heterosexual men who had sex with steady female partners and those who had sex with other female partners, 22% reported unprotected vaginal sex (Ibid). These data suggest that some HIV-positive persons lack the ability to negotiate safer sex.

HIV-positive persons also indicated that their partners could benefit from counseling and support. As noted above, more than half of the needs assessment participants indicated that they struggled with telling sex partners that they were living with HIV. These points suggest that there are not norms that support HIV-positive persons in disclosing their status or asking partners their HIV status.

To address these needs MHAC recommends **multi-session individual level prevention counseling, skills building workshops, partner services, prevention case management and community level interventions.**

Community level interventions should work to reduce the stigma, including internalized stigma, of HIV and encourage communication about HIV status within sexual relationships. Workshops should focus on developing skills in the following areas:

- Communication, including the disclosure of status to and asking the status of sexual partners
- Negotiation of safer sex
- Safer sex skills

When asked what services were or would be helpful, information about safer sex ranked the highest (MDCH 2001, 9). To address this need MHAC recommends **informational sessions**.

Overarching Recommendations for Interventions

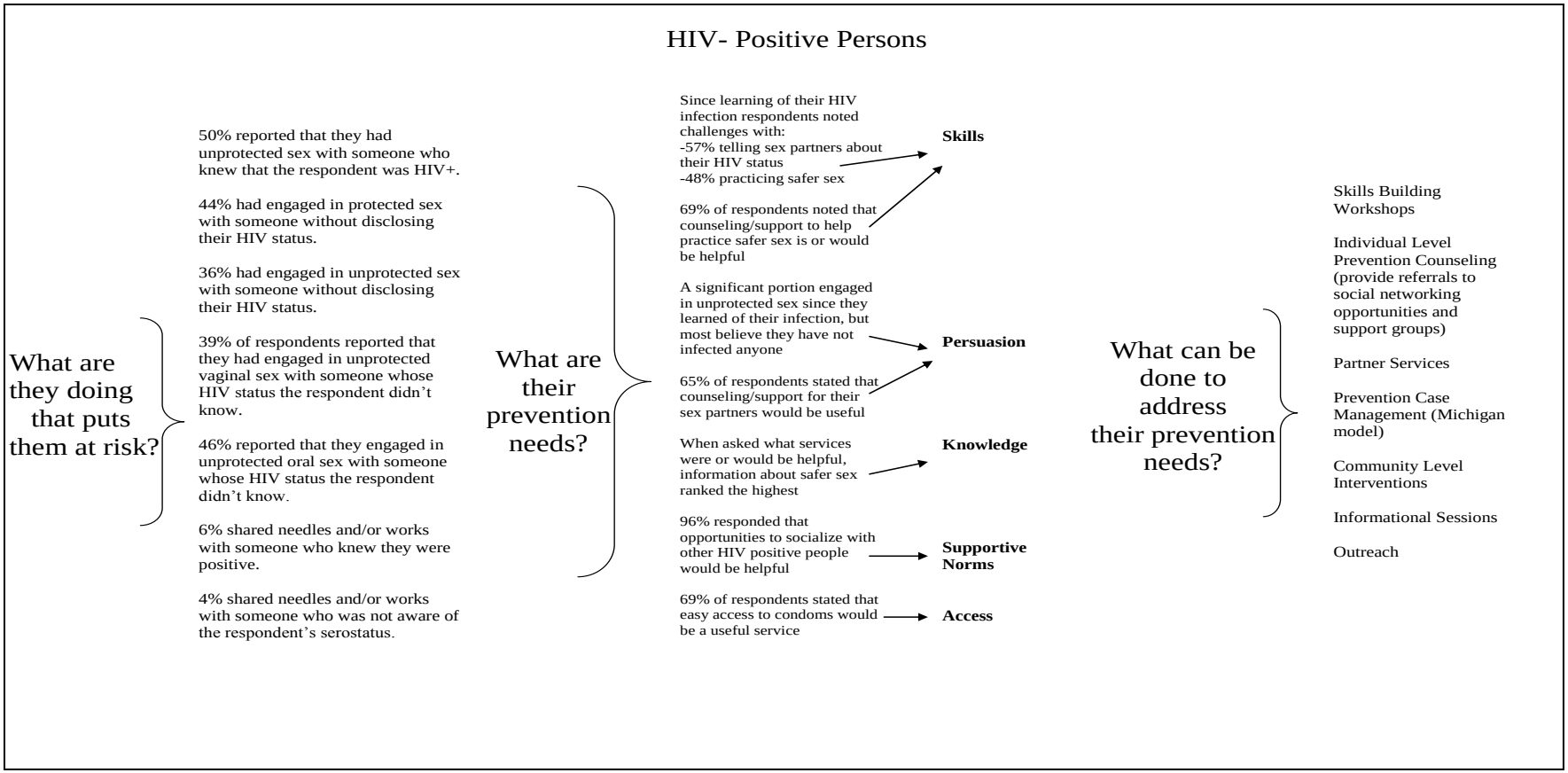
In the statewide needs assessment, 96% of respondents indicated that opportunities to socialize with other HIV positive people would be useful and 62% ranked this as the most useful service (Ibid.). To respond to this, MHAC recommends that all programs targeting HIV- positive persons include social networking opportunities and the provision of internal and/or external referrals to psychosocial support groups. Memorandums of agreement should be in place to ensure referrals are available for all participants.

Sixty-nine percent of respondents stated that easy access to condoms would be a useful service. To address this need MHAC recommends that all prevention interventions provided to HIV-positive persons make condoms freely available to clients.

All interventions should include an anti-stigma component. Reducing the stigma (internal and external) faced by individuals living with HIV may assist them in accessing programs that address ongoing risk of STD acquisition, HIV transmission and disclosure of status.

Gap Analysis Recommendations

The prevention needs and matched interventions listed above were compared to the Community Resource Inventory of prevention services provided in 2008. This comparison revealed that current services do not fully address these prevention needs and that the provision of community level interventions, prevention case management and individual level prevention counseling should be increased from 2008 levels.


HIV- Positive Persons
What are they doing that puts them at risk?
50% reported that they had unprotected sex with someone who knew that the respondent was HIV+.
44% had engaged in protected sex with someone without disclosing their HIV status.
36% had engaged in unprotected sex with someone without disclosing their HIV status.
39% of respondents reported that they had engaged in unprotected vaginal sex with someone whose HIV status the respondent didn't know.
46% reported that they engaged in unprotected oral sex with someone whose HIV status the respondent didn't know.
6% shared needles and/or works with someone who knew they were positive.
4% shared needles and/or works with someone who was not aware of the respondent's serostatus.
What are their prevention needs?
Since learning of their HIV infection respondents noted challenges with:
-57% telling sex partners about their HIV status
-48% practicing safer sex
Skills
69% of respondents noted that counseling/support to help practice safer sex is or would be helpful
A significant portion engaged in unprotected sex since they learned of their infection, but most believe they have not infected anyone
Persuasion
65% of respondents stated that counseling/support for their sex partners would be useful
When asked what services were or would be helpful, information about safer sex ranked the highest
Knowledge
96% responded that opportunities to socialize with other HIV positive people would be helpful
Supportive Norms
69% of respondents stated that easy access to condoms would be a useful service
Access
What can be done to address their prevention needs?
Skills Building Workshops
Individual Level Prevention Counseling (provide referrals to social networking opportunities and support groups)
Partner Services
Prevention Case Management (Michigan model)
Community Level Interventions
Informational Sessions
Outreach

Men Who Have Sex with Men (MSM)

Prevention Needs and Interventions

Many MSM lack access to HIV testing. In a statewide survey on HIV-related attitudes and behaviors of MSM, 23% of participants had never been tested (Lapinski-LaFaive 2004c, 28). Young men and men of color were more likely to have never been tested. The Community Intervention Trial for Youth study (CITY), which focused on young MSM in the Detroit metropolitan area, found that 14% of MSM who have had unprotected anal sex have never been tested (Cottrill 2009).

Most MSM do not think they are at risk for HIV. Of the MSM participating in the statewide survey, 80% thought they had a low or no chance that they would become infected (Lapinski-LaFaive 2004c, 30). The survey revealed that 54% of respondents had not used a condom during their last sexual encounter and 30% never used condoms for anal sex (Ibid., 13 & 21). Of those who had been tested for HIV, only 18% thought they may have been exposed to HIV through sex, 10% worried about transmitting HIV to others and 7% thought they had a health problem related to HIV (Ibid., 29).

To meet these needs MHAC recommends **counseling, testing and referral** services and **individual level prevention counseling. Outreach** and **informational sessions** should be used as recruitment strategies into these interventions.

MSM interviewed for the CITY study revealed a lack of supportive social norms for risk reduction behaviors. Many young MSM have negative attitudes about condom use. The CITY study found that respondents who had unprotected anal sex with main or non-main partners reported higher negative peer norms toward condom use than those who did not report unprotected anal sex (Cottrill 2009). Forty-one percent of respondents who had unprotected anal sex in the last 3 months reported being high during the encounter (Ibid.). The statewide survey showed that respondents who expected negative outcomes associated with asking partners to use condoms were less likely to use condoms when compared to respondents who did not expect negative outcomes (Lapinski-LaFaive 2004c, 26 &27). The report concluded that prevention efforts that seek to encourage condom use should acknowledge and work to counteract the perception that condoms interfere with pleasure and intimacy (Ibid, 34).

The statewide MSM survey also suggested there are not social norms supporting open communication between sex partners. Many MSM reported that they do not talk about HIV with casual or steady partners (Ibid, iv). MSM stated that they did not ask their partner's status or disclosure their own.

To address these needs MHAC recommends **community level interventions** combined with **health communications**. Social norms that promote the following behaviors should be considered when implementing these interventions:

- Avoiding sex when drunk or high
- Using condoms for anal sex

The specific social norms addressed should be determined through local data, as multiple norms may affect these behaviors.

MSM do not have all of the skills they need to protect themselves from HIV. The statewide MSM survey showed that respondents indicated challenges not only with using condoms related to their feelings and negative expectations, but also with using condoms in the context of the sexual encounter

(Ibid., 26). As noted above, MSM reported that they do not talk with partners about HIV. These data indicate a lack of skills to negotiate and communicate with sex partners about condom use and other risk reduction strategies.

To address these needs MHAC recommends **skills building workshops**, **health communications** and **counseling, testing and referral** services. Health communications should be used in the context of social marketing methods. Skills addressed through these interventions should include:

- Communication and negotiation with sex partners
- Risk reduction strategies (in contrast to risk elimination)
- Condom use

African American MSM (AAMSM) & Young African American MSM (YAAMSM)

Prevention Needs and Interventions

There are a variety of social norms influencing behaviors of AAMSM that do not support HIV risk reduction. A statewide study that examined the HIV related needs and risk perceptions of AAMSM concluded that bi- and homosexuality remain highly stigmatized in the African American community (Lapinski-LaFaive and Simpson 2005, 18). AAMSM reported that communicating about homosexuality was not normalized, particularly within families (Ibid.). One consequence of this stigma is that MSM choose not to disclose bi- or homosexual behaviors (Ibid., 19).

National data offers further insight into this issue. AAMSM who report that their parents disapprove of their sexuality also report high rates of sexual risk taking (Miller 2009). Family and community rejection are associated with mental health problems (e.g., depression) and sexual risk behaviors (Ibid.). These points, in addition to the Michigan-specific data, indicate that AAMSM and YAAMSM lack social norms and structures that support their lives as MSM and safer sexual practices.

To address these needs MHAC recommends **structural interventions, prevention case management**, **community level interventions** and **health communications**. Structural and community level interventions should work to increase acceptance of AAMSM and be aimed at AAMSM, YAAMSM and African American communities as a whole. Structural interventions may also focus on school systems, advocating for the use of comprehensive sex education curriculums inclusive of the sexual behaviors of MSM. Prevention case management programs should have memorandums of agreement with mental health and other applicable prevention services that are skilled and experienced in providing services to AAMSM including youth. Health communications may be used as part of social marketing campaigns to fight homophobia on a community level.

Overarching Recommendations for MSM Interventions

Interventions targeting AAMSM and YAAMSM must have strong linkages to mental health and counseling services for survivors of sexual assault. National data suggest that a large percentage of AAMSM experience childhood sexual abuse (Fields et. al.). Childhood sexual abuse has been linked to higher rates of IDU, unprotected receptive anal sex, sex work and sexually transmitted diseases (Ibid.). Interviews with 21 Michigan stakeholders, including staff and providers from community based organizations, health care, state and local health departments showed that their ability to serve YAAMSM could be enhanced by skills building trainings that address working with survivors of sexual

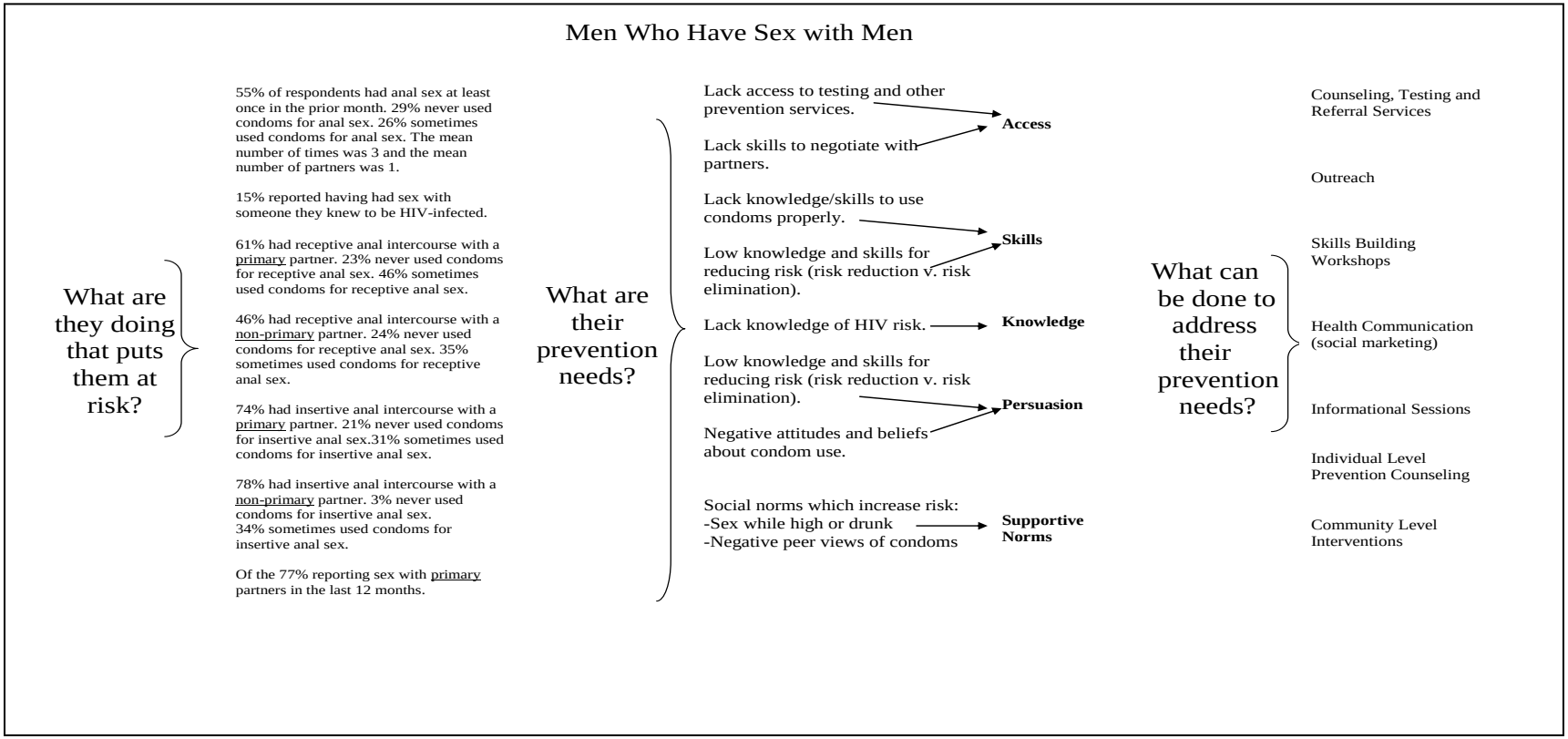
abuse and domestic violence (McNall 2009). MHAC recommends that trainings addressing these issues be made available to all providers working with YAAMSM.

All interventions targeting MSM should have components that address homophobia. These components may be directed at decreasing internalized homophobia (within skills building workshops) or homophobia in the general community (through community level interventions).

Interventions should also address issues related to education and employment. Prevention providers should build relationships with and facilitate referrals to programs that offer free or low-cost education, job training and other related services.

Gap Analysis Recommendations

The prevention needs and matched interventions listed above for MSM were compared to the Community Resource Inventory of prevention services provided in 2008. This comparison revealed that current services do not fully address the prevention needs of MSM. MHAC recommends increasing efforts to provide counseling, testing and referral, prevention case management services and skills building workshops to address these gaps. Additionally MHAC recommends an increase in structural and community level interventions aimed at reducing homophobia and stigma in the general community and increasing supportive norms for using condoms for anal sex.


Men Who Have Sex with Men
What are they doing that puts them at risk?
55% of respondents had anal sex at least once in the prior month. 29% never used condoms for anal sex. 26% sometimes used condoms for anal sex. The mean number of times was 3 and the mean number of partners was 1.
15% reported having had sex with someone they knew to be HIV-infected.
61% had receptive anal intercourse with a primary partner. 23% never used condoms for receptive anal sex. 46% sometimes used condoms for receptive anal sex.
46% had receptive anal intercourse with a non-primary partner. 24% never used condoms for receptive anal sex. 35% sometimes used condoms for receptive anal sex.
74% had insertive anal intercourse with a primary partner. 21% never used condoms for insertive anal sex.31% sometimes used condoms for insertive anal sex.
78% had insertive anal intercourse with a non-primary partner. 3% never used condoms for insertive anal sex. 34% sometimes used condoms for insertive anal sex.
Of the 77% reporting sex with primary partners in the last 12 months.
What are their prevention needs?
Lack access to testing and other prevention services.
Lack skills to negotiate with partners.
Access
Lack knowledge/skills to use condoms properly.
Low knowledge and skills for reducing risk (risk reduction v. risk elimination).
Skills
Lack knowledge of HIV risk.
Knowledge
Low knowledge and skills for reducing risk (risk reduction v. risk elimination).
Negative attitudes and beliefs about condom use.
Persuasion
Social norms which increase risk:
-Sex while high or drunk
-Negative peer views of condoms
Supportive Norms
What can be done to address their prevention needs?
Counseling, Testing and Referral Services
Outreach
Skills Building Workshops
Health Communication (social marketing)
Informational Sessions
Individual Level Prevention Counseling
Community Level Interventions

Injection drug users (IDU)

Prevention Needs and Interventions

Many IDU lack access to sterile syringes and injection equipment. Of the IDU interviewed for the HIV Testing Survey, 32% reported sharing needles and 37% reported sharing injection equipment (Lapinski-LaFaive and Simpson 2004b, 15). Among Detroit IDU who participated in National HIV Behavioral Surveillance (NHBS) interviews, 22.6% reported sharing needles and 46% reported sharing equipment in the last 12 months (Reznar 2009b). These IDU obtained needles from multiple sources, including friends, relatives and drug dealers. The HIV/AIDS and Health Related Needs among IDU in Michigan report describes the difficulties IDU have in obtaining new syringes and works, particularly from pharmacies (Lapinski-LaFaive and Simpson 2004b, 20). NHBS interviews revealed that IDU who had gotten free needles were more likely to use sterile needles (Reznar 2009b). Taken together, these data show that IDU would benefit from increased access to sterile needles and injection equipment.

To address this need MHAC recommends **structural interventions** that concentrate on the following three areas:

- Changing state and local paraphernalia laws/ordinances to allow the purchase and possession of syringes and works without a prescription.
- Educating physicians and pharmacists in order to expand prescription and over-the-counter availability of syringes.
- Expanding syringe exchange, including increasing the number of syringe exchange programs (SEP), the number of services provided at SEP, and the amount of funding and capacity development opportunities available for programs.

Some IDU lack the skills to reduce their risk for HIV. Needs assessment found that many IDU did not clean their syringes according to the Centers for Disease Control and Prevention guidelines although they identify using new or sterile syringes as important and state that they are concerned about reusing syringes (Lapinski-LaFaive and Simpson 2004b, 18). IDU identified addiction and accompanying drug sickness as conditions that lead to sharing injection equipment (Ibid, 20). In addition to risks directly associated with injecting, IDU also have prevention needs arising from their sexual behaviors. Forty-two percent of the IDU interviewed sold or bought sex, and some respondents indicated that their attempts to use condoms were sometimes hindered by their partners (Ibid., 6).

To address these needs MHAC recommends **skills building workshops**. Workshops should focus on developing skills in the following areas:

- Accessing and using sterile equipment
- Cleaning syringes
- Reducing sexual risks
- Drug use management

There are a variety of social norms influencing behaviors of IDU that do not support HIV risk reduction. There is some evidence that there are not social norms supporting open communication about HIV and HCV status among IDU. In the NHBS interviews, 57% of IDU who shared syringes and equipment did not know the other persons' HIV status, and 63% did not know the other persons' HCV status (Reznar 2009b). Ninety percent of the sharing partners were identified as sexual partners, friends and

acquaintances. This suggests that social norms do not support the idea that it is important to tell or ask other IDU their HIV and HCV status.

IDU interviewed for the statewide IDU needs assessment also made statements that reveal a lack of supportive social norms for risk reduction behaviors. Some IDU reported that friends used their syringes without permission (Lapinski-La Faive and Simpson 2004b, 20). Several interviewees indicated that accessing treatment programs made it difficult to reduce their risks because of the drug activity within the facility (Ibid.). These data illustrate the lack of supportive norms to reduce injection related risks.

To address these needs MHAC recommends **community level interventions**. IDU reported that they trust and talk to other injectors; therefore MHAC recommends the use of peers in community level interventions (Ibid., 23). Norms that promote the following behaviors should be considered when implementing these interventions:

- Knowing and disclosing HIV and HCV status with injecting and sexual partners
- Avoiding sharing equipment and needles

Community level interventions targeting administration, staff and clients of drug treatment facilities should focus on creating a safe atmosphere so that participants feel comfortable reporting the sale or use of drugs at the facility.

The relatively high levels of knowledge and self-efficacy IDU report do not translate into reduced risk behaviors. The HIV/AIDS and Health Related Needs among IDU in Michigan report concluded that ongoing risk behavior is the result of complex psychosocial factors (Ibid., 26). In addition, participating IDU identified the importance of and their need for mental health services, including counseling (Ibid., 23).

To address these needs MHAC recommends **counseling, testing and referral** services.
Referrals should be provided to additional counseling and mental health services as indicated. In areas where mental health or counseling services are not available to or culturally appropriate for IDU, MHAC recommends **individual level prevention counseling**.

<u>Overarching Recommendations for Interventions</u>
MHAC recommends that viral hepatitis prevention be included in all interventions for IDU. Injecting drugs is the primary mode of transmission for hepatitis C. Studies show that within 5 years of beginning to inject, 60% to 80% of IDU are infected with HCV (CDC 2001). It is estimated that 50% to 90% of IDU with HIV also have HCV infection (CDC 2005). HIV/HCV co-infection accelerates progression of HCV disease and increases hepatitis C morbidity and mortality with end-stage liver disease being the leading cause of death in co-infected populations (Taylor).

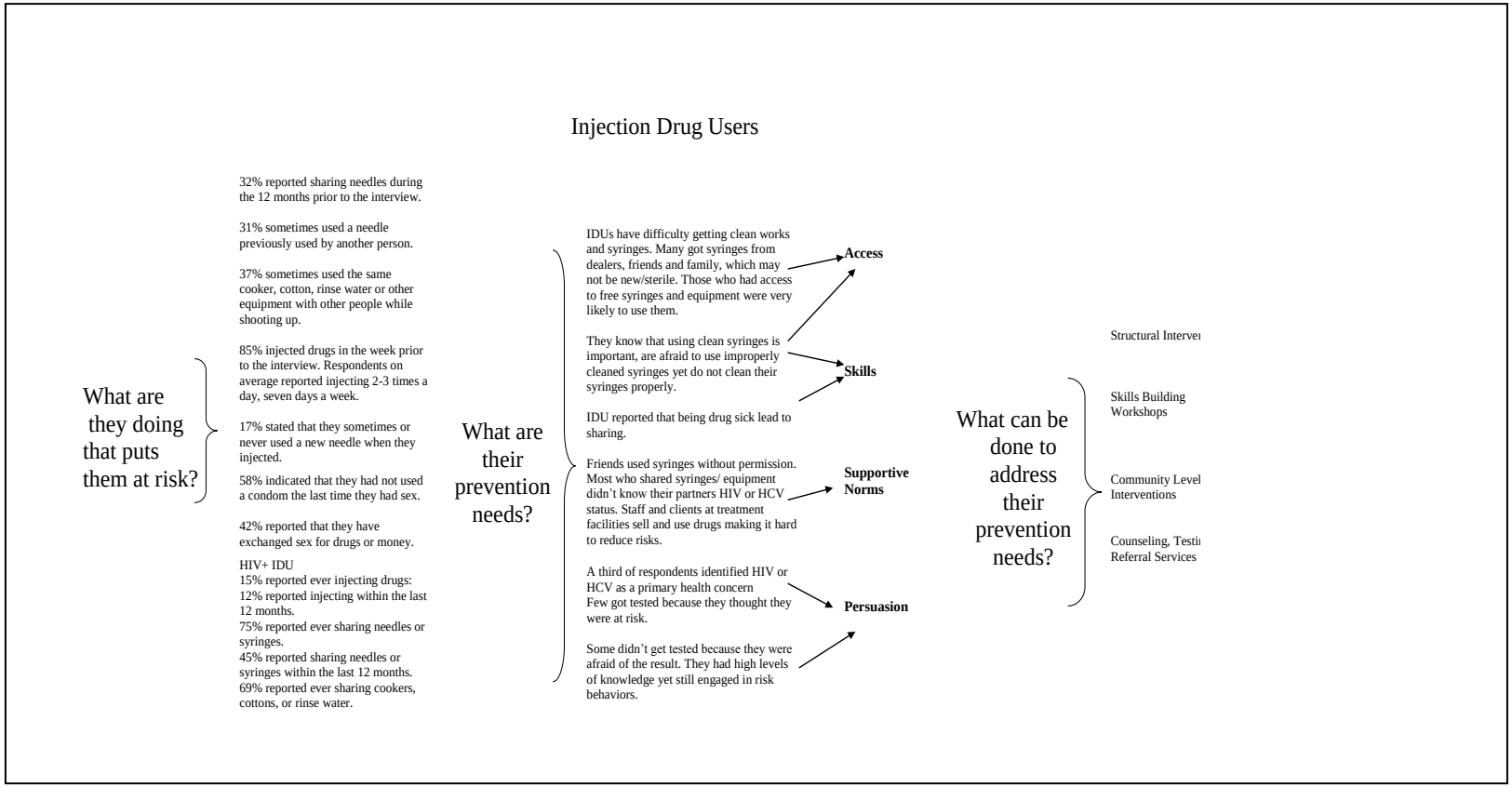
IDU are also at risk for hepatitis B virus through the sharing of needles and drug-preparation equipment. In addition, outbreaks of hepatitis A infection have been reported among IDUs; such outbreaks are believed to occur through both percutaneous and fecal-oral routes (CDC).

MHAC recommends that all interventions for IDU acknowledge the sexual risks of IDU, addressing the needs of heterosexuals, MSM, transgender persons and other sexual minorities. MSM who inject drugs make up 28% of reported IDU cases in Michigan (MDCH 2009b, 2). Studies have shown that transgender persons have high rates of HIV, and some are at risk through injection drug, hormone and silicone use (Herbst et. al. 2007). Intervention materials, role plays and data collection forms should not assume participants are heterosexual or that they identify as male or female. SEP should provide needles in a variety of gauges to meet the needs of persons who inject hormones and silicone.

MHAC suggests that pre-test counseling for IDU incorporate an overdose prevention discussion. The findings of one study suggest that young injectors at highest risk for overdosing are also those at highest risk for HIV infection (Ochoa 2001, 458).

Gap Analysis Recommendations

The prevention needs and matched interventions listed above for IDU were compared to the Community Resource Inventory of prevention services provided in 2008. This comparison revealed that current services do not fully address these prevention needs. These gaps can be addressed through increased emphasis on skills building workshops, structural and community level interventions including the use of peer-led prevention services, when appropriate (e.g. secondary syringe exchange). MHAC also recommends using HIV prevention funds to integrate hepatitis C screening into HIV testing for IDU.


Injection Drug Users
What are they doing that puts them at risk?
32% reported sharing needles during the 12 months prior to the interview.
31% sometimes used a needle previously used by another person.
37% sometimes used the same cooker, cotton, rinse water or other equipment with other people while shooting up.
85% injected drugs in the week prior to the interview. Respondents on average reported injecting 2-3 times a day, seven days a week.
17% stated that they sometimes or never used a new needle when they injected.
58% indicated that they had not used a condom the last time they had sex.
42% reported that they have exchanged sex for drugs or money.
HIV+ IDU
15% reported ever injecting drugs:
12% reported injecting within the last 12 months.
75% reported ever sharing needles or syringes.
45% reported sharing needles or syringes within the last 12 months.
69% reported ever sharing cookers, cottons, or rinse water.
What are their prevention needs?
IDUs have difficulty getting clean works and syringes. Many got syringes from dealers, friends and family, which may not be new/sterile. Those who had access to free syringes and equipment were very likely to use them.
Access
They know that using clean syringes is important, are afraid to use improperly cleaned syringes yet do not clean their syringes properly.
Skills
IDU reported that being drug sick lead to sharing.
Friends used syringes without permission. Most who shared syringes/ equipment didn't know their partners HIV or HCV status. Staff and clients at treatment facilities sell and use drugs making it hard to reduce risks.
Supportive Norms
A third of respondents identified HIV or HCV as a primary health concern
Few got tested because they thought they were at risk.
Persuasion
Some didn't get tested because they were afraid of the result. They had high levels of knowledge yet still engaged in risk behaviors.
What can be done to address their prevention needs?
Structural Interve
Skills Building Workshops
Community Level Interventions
Counseling, Testi
Referral Services

High Risk Heterosexuals (HRH)

Prevention Needs and Interventions

Many heterosexuals,[4] including HRH, do not know their HIV status. Data from the National HIV Behavioral Surveillance (NHBS) interviews of heterosexuals in Detroit showed that 38% of men, 29% of women and 51% of youth had never been tested for HIV (Reznar 2009a). Of the respondents, 68% reported a health care visit in the past 12 months, but only a 31% of them were offered an HIV test at that visit (Ibid.).

Some HRH accessing sexually transmitted disease (STD) clinics do not perceive themselves to be at risk and do not test for HIV. Of the HRH who participated in the HIV Testing Survey (HITS) and had not been tested in the prior year, 60% thought it was unlikely they had been exposed to HIV through sex (MDCH 2002, 9). All of these individuals were seeking care at an STD clinic.

To address these needs MHAC recommends **counseling, testing and referral** services and **structural interventions**. Structural interventions should focus on making HIV testing a standard of care in health care settings and providing appropriate referrals into care and prevention services.

Many HRH do not think they are at risk for HIV though they engage in risky behaviors or live in high prevalence areas. HITS revealed that 46% of males and 36% of females never used condoms with primary sex partners for vaginal sex (MDCH 2002, 30). Twenty percent of males and 46% of females never used condoms for vaginal sex with other sex partners.

To address these needs MHAC recommends **outreach**, **individual level prevention counseling**, and **community level interventions**. Individual level prevention counseling should be provided in venues that already reach HRH (e.g., at syringe exchange programs for partners of IDU, at infectious disease clinics for partners of HIV-positive persons with repeat STD). Community level interventions should include a health communication component. Health communications campaigns should target HRH and other heterosexuals to raise awareness of HIV risks and promote the importance of testing.

Commercial Sex Workers (CSW)

Prevention Needs and Interventions

Sixty-two percent of CSW interviewed in a statewide needs assessment reported that they never used risk reduction strategies with their primary partners (Lapinski-LaFaive and Simpson 2004a, 5). The same assessment showed that 60% did not talk to their primary partners about HIV.

To address these needs MHAC recommends **individual level prevention counseling** and **community level interventions.** Community level interventions targeting CSW should concentrate on changing norms to support using risk reduction strategies with primary partners.

[4] The National HIV Behavioral Surveillance project, interviewed 777 heterosexuals living in census tracks of the Detroit metropolitan area with high rates of heterosexually transmitted HIV. Because these individuals were not identified as HRH according to the definition on page 7, they are referred to as heterosexuals in this section.

CSW had additional HIV prevention needs tied to drug use. Many participants said that they had begun selling sex due to their drug use and continued to sell sex because of their drug habit (Lapinski-LaFaive and Simpson 2004a, 9). When asked to describe their biggest worries or problems few of the participants mentioned their drug use. However, CSW stated that they had considered quitting sex work or had quit in the past but continued with or returned to sex work because they needed money for drugs and did not have the skills to do other jobs (Ibid., 9 & 10).

To address these needs MHAC recommends **individual level prevention counseling, community level interventions** and **structural interventions**. Individual level prevention counseling should be used to explore ambivalence about reduction or elimination of drug use, and ways to reduce risks through harm reduction strategies. Community level interventions should focus on changing norms around drug use. Structural interventions should be directed at strengthening referrals to:

- Education
- Job training
- Substance use disorder treatment

Some CSW lack the knowledge and skills to reduce their risk for HIV. Many CSW reported performing visual inspections of clients' genitalia to determine if they had an STD (Ibid., 13). A number also mentioned cleaning themselves after sex to avoid HIV. A significant portion of participants reported that they were most likely to be able to successfully negotiate use of condoms or other risk reduction strategies with clients when they were not drug sick (Ibid., 16). As noted above, CSW sold sex to support drug habits, which may reveal a lack of drug use management skills.

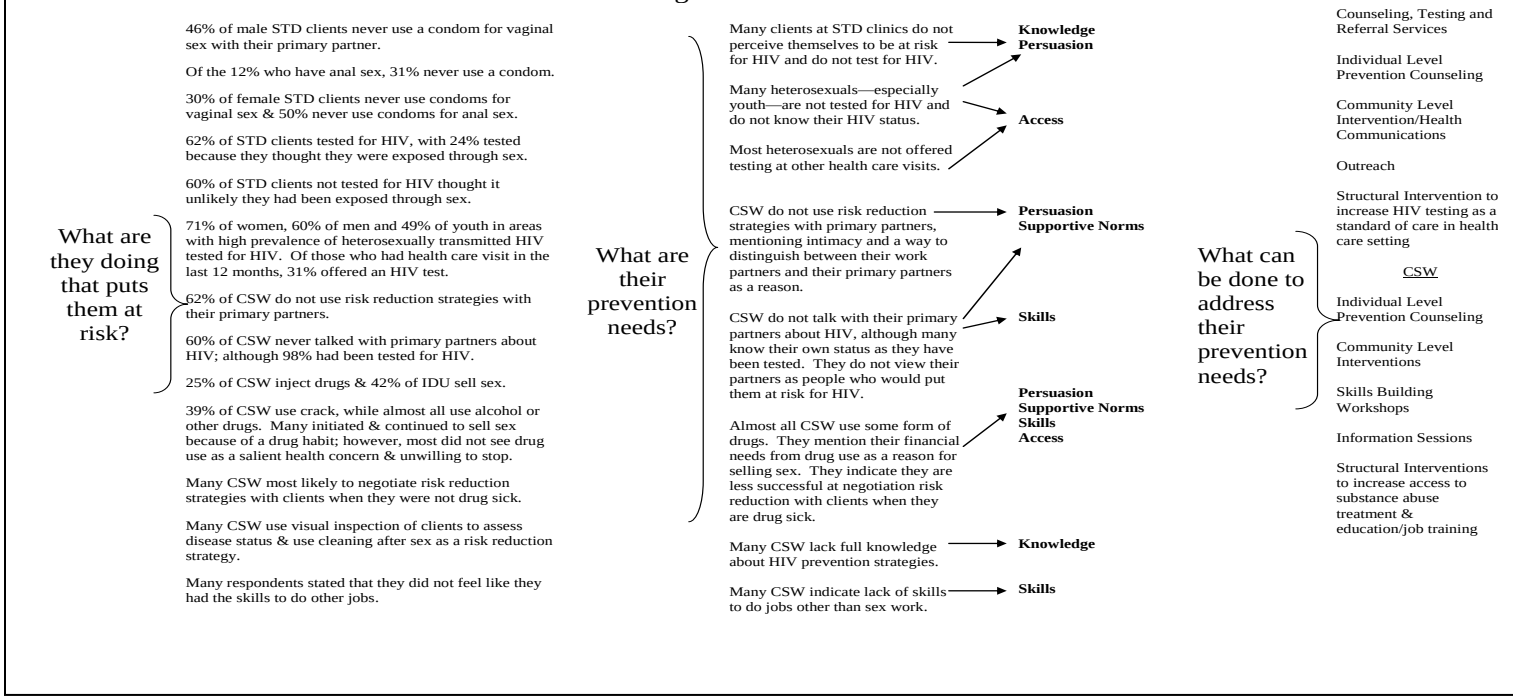
To address these needs MHAC recommends **informational sessions** and **skills building workshops**. Informational sessions should include information on effective risk reduction strategies for CSW. Workshops should build skills in:

- Negotiation of safer sex
- Drug use management

<u>Gap Analysis and Recommendations</u>

The prevention needs and matched interventions listed above for HRH were compared to the Community Resource Inventory of prevention services provided in 2008. This comparison revealed that current services do not fully address these prevention needs. MHAC recommends that to address these gaps that the provision of individual level prevention counseling, structural interventions, and community level interventions be increased.

High Risk Heterosexuals



Transgender Persons

The impact of HIV on transgender[5] persons was an important concern of the Prevention Plan Workgroup as this plan was developed. Although there was anecdotal information about transgender persons and HIV in Michigan, there were no Michigan-specific data available to MHAC.

National data shows that transgender persons are at risk for HIV. A meta-analysis of studies examining HIV prevalence and risk behaviors found that transgender persons are at risk for HIV due to sexual behaviors, injection drug, hormone and silicone use (Herbst 2007). This analysis found that the average prevalence rate for male to female transgender women was 27.7% from four studies that reported rates of laboratory confirmed HIV infections (Ibid., 8). One study that provided HIV tests to female to male transgender men was included in this analysis. It reported a two percent prevalence rate among female to male transgender men (Ibid., 8).

Transgender persons may identify as, and use services for, any of the prioritized populations. While they should be provided services in congruence with their self-identified gender and risk behaviors, transgender persons may have prevention needs that are not addressed by interventions aimed at the prioritized populations. These needs may best be determined at the local level and addressed through interventions explicitly designed for transgender persons.

MHAC recommends that all statewide needs assessments collect data on gender identity and expression, even when they are not specifically targeted to transgender communities. It is vital that data collection methods be improved to better capture and understand the complexities among these diverse communities.

Furthermore, MHAC recommends that providers seek out opportunities to learn from (and build skills to better serve) transgender persons.

[5] Transgender is an umbrella term used to describe people whose gender identity or gender expression differs from that usually associated with their sex as assigned at birth. Individuals who "fit" this definition may or may not self-identify as transgender.

Integration of Services and Referrals

Individuals who are at increased risk for HIV are often at risk for other diseases and have psychosocial, physical and spiritual needs that cannot be met through HIV prevention interventions. HIV prevention providers need to be familiar with the myriad issues that affect their clients and prepared to provide additional services or make referrals to external programs.

Integrating services maximizes the opportunity that providers have to impact the health of at-risk populations. Providers should assess the services they are currently providing and work on reducing inefficiencies in parallel service delivery systems. To promote the integration of services, MHAC recommends that all providers:

- Provide integrated prevention messages. Intervention curricula and materials should address HIV, sexually transmitted diseases (STD), viral hepatitis and tuberculosis (TB) as appropriate for target populations
- Use risk assessment tools that inquire about risk behaviors for HIV, STD, viral hepatitis, TB, substance use, mental health disorders and socioeconomic factors that impact health outcomes
- Seek out cross-training opportunities
- Address barriers to services identified through local needs assessments

In addition to the efforts of individual HIV prevention providers to promote integration of services within organizations, opportunities should be sought to enhance the integration of HIV prevention services into existing care, prevention and supportive services. Particular opportunities may exist in these areas:

- Making HIV testing a standard of care in health care and sexually transmitted disease clinics
- Incorporating HIV prevention messages and services into family planning, substance use disorder and mental health services
- Enhancing the cultural competence of substance use and mental health treatment providers to serve MSM, HIV-positive and transgender persons, and individuals who do not want to or cannot stop using drugs

Referrals play an equally important role in meeting the complex needs of clients. Providers should develop partnerships with agencies to support referrals that address clients' prioritized needs. Partnerships between providers should be formalized in memorandums of agreement that clearly outline the roles and responsibilities of each partner.

Referrals should comply with the MDCH Prevention Referral Guidelines, which can be found at www.mihivnews.com. The guidelines outline the active role of prevention staff in ensuring clients receive appropriate services:

Referral is the process by which a client's immediate needs for care, prevention and supportive services are assessed and prioritized. Clients are provided with assistance (e.g., setting up appointments, providing transportation) in accessing referral services. Referral also includes reasonable follow-up efforts necessary to facilitate initial contact with prevention, care and psychosocial services and to solicit clients' feedback on satisfaction with services (MDCH 2007, 2).
Providers should maintain a referral resource guide that contains the essential information about referral partners. At a minimum, providers should be able to facilitate referrals for the following services:

- Partner services
- HIV-specific medical care
- Primary medical care
- Prenatal and reproductive healthcare
- STD testing and treatment
- Hepatitis screening
- Hepatitis A and B vaccination
- Mental health services
- Substance use disorder treatment
- Domestic violence and sexual assault counseling and related services
- TB testing and treatment
- Syringe exchange
- Case management

In Michigan, RW grantees (A – F) have established a high level of coordination, cooperation and partnership among stakeholders and providers seeking to improve care and treatment services for people living with HIV/AIDS. Current quality initiatives allow Michigan RW grantees to better assess the extent to which HIV health services are consistent with Health and Human Services Guidelines and that services are consistent with guidelines for improving access to and quality of HIV services.

Monitoring: Michigan RW grantees and the MCPQC routinely assess the quality of inputs, quality of service delivery according to standards, and the quality of health outcomes, in order to continually improve the continuum of care system in the State of Michigan. Systematic processes are in place for statewide planning, implementing and evaluating quality management and continuous quality improvement programs and activities by RW grantees.
Additionally, MDCH, DHWDC has designated a Quality Management Consultant to coordinate the activities of the MCPQC and to manage quality activities of the Part B grantee, including training on quality indicators, quality assurance of the ADAP and the Michigan Dental Program, and administrative and fiscal components of Part B. MDCH, DHWDC has developed a system and timeline to ensure routine data collection and analyses of data are conducted and reported to programs and provider organizations to assure quality improvement in data collection, documentation and service provision.

Proposed Statewide HIV/AIDS Plan
This section provides an overview of the cross-cutting issues and gaps identified during the Plan process. It incorporates the Strategic Planning process conducted by the Division during 2011, and highlights the continuous process of assessing client and system needs process that informs the resource allocation decisions and activities funded by the DHWDC. The DHWDC, MDCH, continues to refine and address the goals below, taking into clear account the statewide goals of integration of RW Parts, Prevention and Care planning and funding and alignment with the National HIV/AIDS Strategy. The following goals and objectives were guided by the comprehensive plans completed by multiple statewide entities, MCPQC, RW Parts A-E, MHAC, SEMHAC involved in the collaborative process of providing seamless HIV care and service delivery in Michigan.

Goal 1: To reduce the burden of STIs including HIV and hepatitis C by facilitating and providing high quality prevention, care, and disease intervention services that address social determinants of health.

Objective 1.1: Decrease the number of new STI, HIV, and hepatitis C infections Indicator: Increase from 65% to 80% the number of individuals newly diagnosed with HIV who are successfully linked to care and treatment for HIV disease within three months of diagnosis.

Recommended Strategies:

1. **Improve Linkage to Care-**increase EIIHA efforts; integrate Prevention and Care efforts and integrate funding (HRSA and CDC); explore central intake and analyze referral process across RW Parts and other providers.

2. **Reduce Unmet Need-**EIIHA Matrix populations focus; increase numbers of medical providers who are trained/knowledgeable in HIV care continuum.

Target Indicator: Increase by 30% the number of HIV-infected clients reported in CAREWare that are tested at recommended intervals for STIs.

- Work with STI Section to develop a communication plan for promoting CDC/HRSA screening guidelines statewide. Promote cross-training of Prevention and Care staff involved in "test to treat" continuum to increase awareness of need for comprehensive testing, data reporting, and coordinated prevention and care efforts in the lives of PLWH/A.

Objective 1.2: Improve the quality of HIV/AIDS, STI, and hepatitis C-related services funded by the Division.

Target Indicator: Increase by 40% the collection and documentation of the HIV Quality Indicators identified by the Michigan Cross Parts Quality Collaborative (MCPQC).

Progress to date:

- Baseline of current collection of Quality Indicators in CAREWare established.

- Training needs identified on Quality Indicators for sub-recipients (contractors).

- During 2011 and early 2012, trainings were provided to all Parts B and D sub-recipients on accurate data entry into CAREWare , and analysis and monitoring of statewide Quality Indicators. The QIs will continue to be monitored by the DHWDC Data Team staff during 2012-13, reported in Quarterly Progress Reports submitted to Part B Program staff, and analyzed by the Linkage to Care Workgroup. Outcomes will be assessed in late 2012 to identify additional training needs.

Goal 2: Facilitate systems change necessary to improve the health status of impacted communities, with emphasis on racial, ethnic and sexual minorities.

Objective 2.1: Improve Statewide HIV/AIDS Data Integration and Integrity Integration of CAREWare onto one server-integrating Detroit (EMA) data with Parts B and D, working on data accessibility from Part Cs.

- **CW User Data Integrity:** Discussed technical trainings provided above-
- **Promote Collaboration among RW Parts-Statewide HIV Planning goal.** MCPQC has made huge strides in creating a collaborative, inclusive planning environment, regular analysis of data and outcomes contributing to sound resource allocation decisions based on data and a Statewide HIV Plan--reducing duplication, scarcity of resources in some areas, lack of coordination of referrals and access to care—and a statewide venue for discussion of cost-effective, needs-based adaptation to the changing medical environment, as ACA is implemented.
- **Facilitate the integration and coordination of HIV, STIs, hepatitis C and TB testing and treatment; coordinate prevention and care planning and mutual support.**
- **Evaluate current data collected on Transgender populations; identify health needs, barriers and gaps in care, service accessibility and utilization patterns. Identify effective service provision strategies for transgender populations.**

Goal 3: Work to assure that the care and prevention needs of racial, ethnic, and sexual minorities are met in a rapidly changing environment, with emphasis on HIV, STIs and hepatitis C.

Objective 3.1: Increase targeting in publically-supported HIV and STD prevention, testing and treatment sites to populations most affected by these diseases.

Target Indicator: Increase by 30% the number of HIV-infected clients reported in CAREWare that are tested at recommended intervals for STDs.

- Work with MATEC and MPCA to increase clinical provider awareness of the need for comprehensive testing and CDC recommendations.
- Continuous analysis of unmet need in Michigan and strategies to address service quality and health disparities reduction efforts for racial, ethnic, and sexual minority populations.
- Enhance collaboration of consumers in prevention and care efforts; increase mechanisms for consumer input and feedback.

Goal 4: Prioritize and strategize to meet the unique needs of women, infants, children, and youth (WICY) in state and systems level planning in the face of policy changes and categorical funding

instability, with emphasis on perinatal prevention, retention in care, and expanded services for young MSM.

- **Perinatal Prevention –** Routinize first and third trimester testing of all pregnant women in Michigan. Sustain the use of FIMR/HIV Project methodology for the assessment and correction of gaps in systems of care.
- **Supportive Services –** Address gaps in the continuum of care for WICY and maintain supportive services essential for retaining WICY in care and improving treatment adherence.

Movement toward a Statewide Quality Plan

In the past two years, Michigan has made a serious effort to endorse and support more collaborative statewide HIV planning. Nearly three-quarters of MDCH prevention funds are allocated to testing, both targeted and routine, in the Detroit EMA. Counseling, testing and referral and partner counseling and referral services continue to serve as a primary link between primary HIV prevention services and programs supported under the RW services. Early knowledge of serostatus and entry into appropriate care and treatment are essential to preventing and delaying the onset of HIV-related illness in individuals with HIV infection. Through the process of referral, HIV-infected individuals are linked to appropriate services, including medical care, case management, and mental health services.

Outreach efforts have focused on connecting with private providers to encourage testing for HIV, and to raise awareness of the need to test among high-risk groups. Provider education and raising awareness of the need to test will be a major focus for Outreach in 2013. DHWDC is working with the MPCA and MATEC to create a unified approach to providing HIV awareness and education in Michigan.

Fiscal and Program Monitoring

Currently, Part A and B grantees are working to align program standards statewide, through the work of the MCPQC Standards Committee. DCH conducts fiscal and program monitoring on all funded contractors. Fiscal monitoring includes: review and approval of draft and final contractor budgets to monitor allowable costs and administrative caps; review of monthly FSRs; review of semi-annual reports on allocations and expenditures by service category; and, technical assistance and support to contractors through the year on fiscal issues. Comments on budgets are documented in writing and kept in the contract files.

Annually, MDCH scores contractors' level of risk is scored as low, moderate, or high. Contractors with a score of moderate or high received a fiscal site visit. In compliance with new HRSA HAB monitoring expectations the Division will begin annual site visits at all contractors during calendar year 2012, regardless of identified risk levels.

The Division also continues to monitor compliance with CLAS Standards, Universal Standards, Standards for Medical Case Management and Standards for Non-medical Case Management on an annual basis.

Vendors submit invoices (FSRs) monthly to MDCH's Accounting Operations office for payment and routinely monitored. All contractors must be registered in Michigan's vendor payment system to receive payments via electronic funds transfer. FSRs are received by MDCH Accounting Operations staff, audited, and paid by entering a payment voucher transaction into the State's accounting system.

Section IV. HOW DO WE MONITOR OUR PROGRESS?

This plan provides a roadmap for the Division to develop annual work plans within and across units and monitor progress towards stated goals. As a living document, the plan will be reviewed and refined as needed.

Implementation and will be a shared responsibility of all staff within the Division with leads within each Section and Unit. Each unit will collect data to measure success and review progress on plan goals and strategies monthly at the unit level. Cross-unit discussion of shared goals will occur at least quarterly, as will Division-level meetings to review progress.

The Strategic Plan Work Group composed of staff from all units and levels will take responsibility for monitoring and recommending refinement and revisions. The Strategic Plan Work Group will:

1. Review annual work plans to assure that they address key goals and strategies in the plan.
2. Specify collection of baseline and progress data.
3. Work with Division staff to support and assure that baseline and progress data on key indicators are obtained and reviewed to monitor progress towards plan goals.
4. Assure that all staff as well as Division stakeholders (Michigan HIV/AIDS Council) receive written summary report providing feedback on strategic plan progress and challenges.
5. Obtain regular input on external events and factors that need to be addressed by the Division and assess their implications for the Division and its stakeholders.
6. Recommend changes in plan strategies or indicators as appropriate, based on this review.

A Note on Using this Plan and the Need for Supplemental Local Data

This plan was deliberately devised to provide an overview of prevention needs and recommended strategies for the four prioritized behavioral groups at a statewide level. It does NOT provide a detailed prescription of which specific intervention models should be provided to individual subpopulations within the behavioral groups.

The prioritized populations described in the plan encompass numerous subpopulations that have distinct prevention needs that may be reflected in or missing from this macro level analysis. This approach was intentional, as MHAC was cognizant that there was no feasible way to include all of the richness and diversity of local (sub)populations and their needs in one plan. Therefore the population sections do not include all of the data needed to select or create an effective intervention for a specific subpopulation in a particular community.

MHAC encourages readers to use this plan as a beginning point. Local data must be used to complement, expand, and narrow down the recommendations in this plan. The flow charts following each population section provide a framework for thinking about the types of data that should be considered when doing local assessments:

- What is the population doing to put themselves at risk for acquiring or transmitting HIV?
- What are their prevention needs?
- Which categories do the needs fall into (access, skills, persuasion, supportive norms or knowledge)?
- Which interventions address these needs?

Local needs assessments can be done through a variety of mechanisms, including:

- Surveys
- Interviews
- Observation
- Focus Groups

While local needs assessment can and should include input from agency staff and other service providers, agencies should prioritize seeking input directly from at-risk individuals in their service area.

Local data about risk populations can also be gathered from other sources:

- County level epidemiological data
- Care or prevention service data
- Risk assessment forms

The importance of local data cannot be overstated. In order to select and implement effective interventions local data must be used along with the broad recommendations of this plan. Specifically MHAC encourages the use of local data to:

- Inform the choice of interventions (e.g., individual or group level, single or multi-session, location, integration opportunities)
- Determine effective recruitment and retention strategies
- Adapt evidence-based interventions

MHAC encourages all providers to seek training and support to increase their capacity to gather, analyze and apply local data to inform program planning.

Monitoring and Evaluation Plan

In Michigan, RW grantees (A – F) have established a high level of coordination, cooperation and partnership among stakeholders and providers seeking to improve care and treatment services for people living with HIV/AIDS. Current quality initiatives allow Michigan RW grantees to better assess the extent to which HIV health services are consistent with Health and Human Services Guidelines and that services are consistent with guidelines for improving access to and quality of HIV services.

Monitoring: Michigan RW grantees and the MCPQC routinely assess the quality of inputs, quality of service delivery according to standards, and the quality of health outcomes, in order to continually improve the continuum of care system in the State of Michigan. Systematic processes are in place for statewide planning, implementing and evaluating quality management and continuous quality improvement programs and activities by RW grantees.

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